

MARYLAND STATE DEPARTMENT OF HEALTH,  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00896

1. DECEASED NAME (Type or print)		First <b>Willard Preston</b>	Middle <b>Archer</b>	Last <b>Archer</b>	20. DATE OF DEATH Month <b>JANUARY</b>	Day <b>18</b>	Year <b>69</b>	2b. HOUR <b>4A</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		S. DATE OF BIRTH <b>January 24, 1918</b>	6. AGE (In years last birthday) <b>50</b>		IF UNDER 1 YEAR MONTHS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b>		MIN <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Harford</b>				
10. CITY OR TOWN OF DEATH <b>Havre de Grace</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Harford Mem. Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Funeral Director</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Funeral</b>						
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <b>Md</b>		13b. CITY OR TOWN <b>Fallston</b>		13c. INSIDE CITY LIMITS? <b>YES</b>		13e. STREET AND NUMBER <b>203 Connally Rd</b>						
14. FATHER'S NAME First <b>Walter</b>		Middle <b>H.</b>	Last <b>Archer</b>	15. MOTHER'S MAIDEN NAME First <b>Loretta</b>		Middle <b>Standiford</b>	Last <b>(D)</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW - II</b>		17. INFORMANT <b>Walter H. Archer, Benson, Maryland 21018</b>		Address						
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>Hypocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Heart Disease</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? <b>YES</b>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> If either, notify medical examiner		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City of Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <b>1-12, 1964</b> , to <b>1-18, 1964</b> , that (I) (we) last saw the deceased alive on <b>1-18, 1964</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Dante N. Monakil, M.D.</b>		22c. DATE SIGNED <b>1/18/69</b>		22d. DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR		STAFF PHYS. <input type="checkbox"/>						
22e. ADDRESS <b>211 N. Union Ave. Havre de Grace, Md.</b>												
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>21 Jan. 69</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Mountain Christian Church</b>		23d. LOCATION (City or Town) <b>Joppa, Harford</b>		(County) <b>Maryland</b>				
24. FUNERAL DIRECTOR <b>Tanning Funeral Home, Aberdeen, Md. 21001</b>		ADDRESS <b>Tanning</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 21 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

100% "Peanut")

medium density

(a) condition: medium density

100% medium density medium density

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death, if necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06897

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) <b>James</b>			First <b>James</b>	Middle <b>J.</b>	Last <b>Bailey</b>	2a. DATE KNOWN <input type="checkbox"/> Month <b>Jan</b> Day <b>11</b> Year <b>1969</b>	2b. HOUR <b>8:48 AM</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Nov. 8, 1952</b>	6. AGE (in years last birthday) <b>16</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS DAYS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b>	IF UNDER 24 HRS MIN. <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Harford County,</b>		
10. CITY OR TOWN OF DEATH <b>Fallston</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Fallston Md.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Fallston</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>Box #73, Rockord Road</b>	
14. FATHER'S NAME First <b>Jack</b>		Middle <b>Bailey</b>		15. MOTHER'S MAIDEN NAME First <b>Katherine B. Lawson</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>None</b>		17. INFORMANT <b>Mr. Jack Bailey</b>		ADDRESS <b>Same</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). <b>Fracture neck, Brain Concussion and Hemorrhage INSTANT</b> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture neck, Brain Concussion and Hemorrhage INSTANT</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Auto Accident</b> DUE TO, OR AS A CONSEQUENCE OF (c)								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>819.9</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1, or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> <b>Rt 152 Fallston</b>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. <b>Rt 152 Fallston Harford, Maryland</b>		City or Town	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>Philip W. Heuman</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>Philip W. Heuman, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED <b>Jan. 11, 1969</b>		
EXAMINER'S NAME (Type) <b>307 Hickory Ave., Bel Air, Md. 21014</b> ADDRESS(Street, city, town, or county)								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/16/69</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Baltimore National</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>		
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. 5305 Harford Road 21214</b>		ADDRESS		25a. DATE REG'D BY REGISTRAR <b>JAN 14 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Ruck</b>		

Part 1 - Part 2

1. Introduction

2. Methods

3. Materials

4. Results

5. Discussion

6. Summary

7. References

8. Acknowledgments

9. Author's

10. Notes

11. Figures

12. Tables

13. Appendixes

14. Abbreviations

15. Glossary

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00903

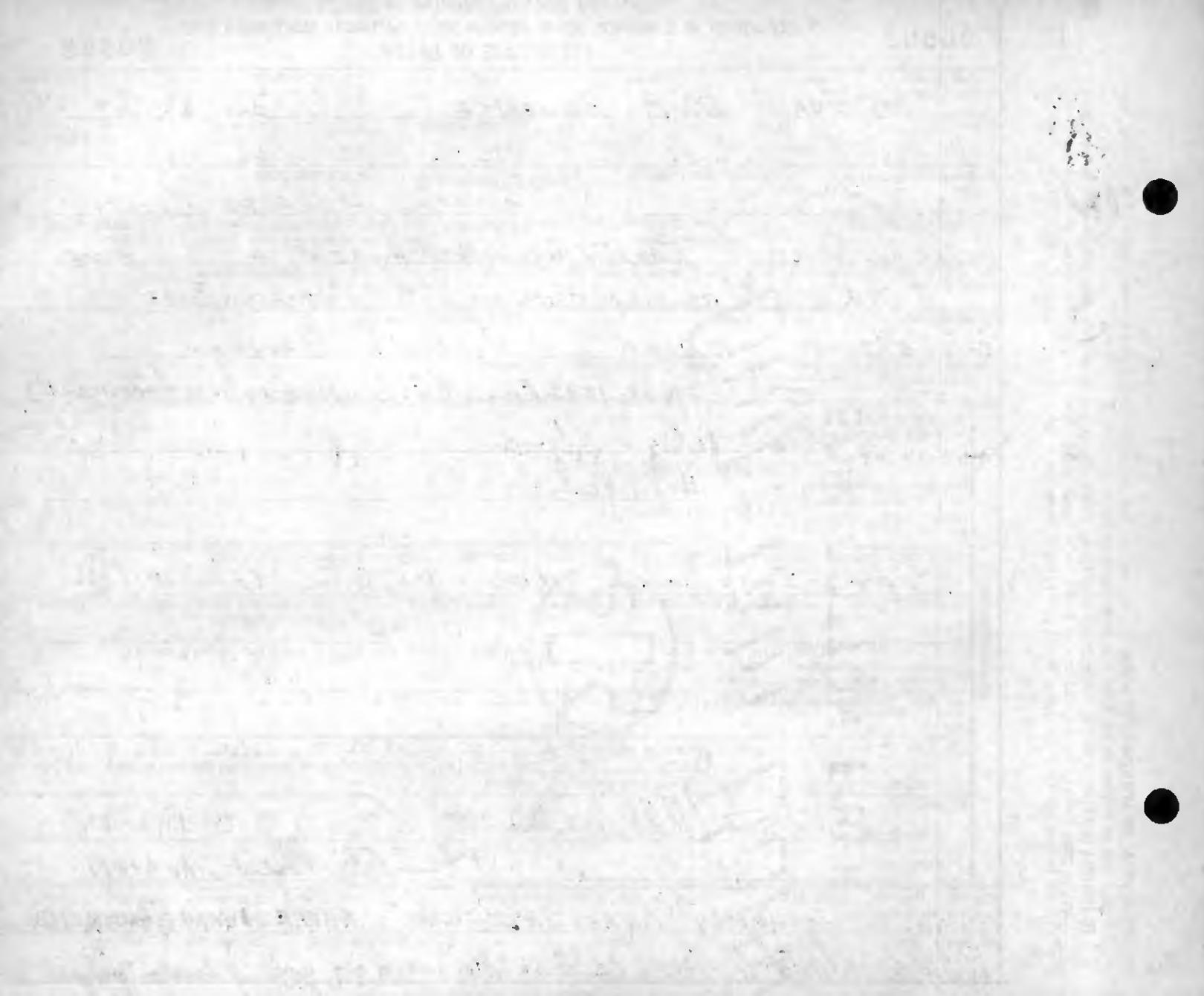
CERTIFICATE OF DEATH

00898

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in event of any emergency.

1. DECEASED-NAME (Type or print) <b>MRS EVA MAE BAUALITZ</b>				First	Middle	Last	2a. DATE OF DEATH Month <b>Jan.</b> Day <b>23</b> , Year <b>69</b>	2b. HOUR <b>6:55 P.M.</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>7-7-1902</b>		6. AGE (In years last birthday) <b>66</b> YRS.		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN.
7a. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>HARFORD County</b>					
10. CITY OR TOWN OF DEATH <b>HAVRE DE GRACE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Brevier Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSE WIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>HARFORD ABERDEEN</b>		13c. CITY OR TOWN <b>ABERDEEN</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1 MADISON PLACE</b>			
14. FATHER'S NAME First <b>GEORGE BRUCE</b>		Middle <b>Brown</b>		15. MOTHER'S MAIDEN NAME First <b>VIRGINIA PERRYMAN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes, no, or unknown</b>		16b. SOCIAL SECURITY NO. <b>216-48-4282</b>		17. INFORMANT <b>EDNA M. CURRY - 1 MADISON PLACE, ABERDEEN, MD</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia Edema</b>											
342 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Heart Failure</b>											
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Heart Failure</b>											
DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Sep 29 to dec 26 alive. Nausea, Parkinson's Disease</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <b>1965</b> , to <b>1/23, 1969</b> , that (I) (we) last saw the deceased alive on <b>1/23, 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Arnold S. Bawley / P.O. Rodney, MD</b>		22c. DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>1/26/69</b>					
22d. PHYSICIAN'S NAME (Type) <b>R. Madison Mitchell, HAVRE DE GRACE, MD</b>		22e. ADDRESS <b>8 Law St, Aberdeen, MD 21001</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>JAN 26, 1969</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>ANGELHILL CEM.</b>		23d. LOCATION (City or Town) <b>HAVRE DE GRACE HARFORD, MD.</b>		(County)		(State)	
24. FUNERAL DIRECTOR <b>R. Madison Mitchell, HAVRE DE GRACE, MD</b>		ADDRESS		25a. RECD BY REGISTRAR <b>JAN 27, 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. ...</b>					



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH						00899			
1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Darlington</b>		c. LENGTH OF STAY IN lb <b>11 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Darlington</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Flintville Road</b>			d. STREET ADDRESS <b>Flintville Road</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>ELLEN</b>	Middle <b>L.</b>	Last <b>BLACKBURN</b>	4. DATE OF DEATH	Month <b>January</b>	Doy <b>26,</b>	Year <b>1969</b>	
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 17, 1889</b>	9. AGE (In years last birthday) <b>79</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Ash Co., N.C.</b>			12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Noah Long</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT Address <b>Charles D. Blackburn, Darlington, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4369</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c)			<b>Generalized Arteriosclerosis and frequent Small Cerebral Vasospasms</b>			INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>			20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>May 17, 1969</b> to <b>1/26, 1969</b> , that (I) (we) last saw the deceased alive on <b>1/14, 1969</b> , and that death occurred at <b>2:30 P.M.</b> , from causes and on the date stated above.									
22a. SIGNATURE <b>Dudley Phillips</b>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22b. PHYSICIAN'S NAME (Type) <b>Dudley Phillips</b> M.D.			22d. ADDRESS <b>Darlington, Maryland</b>			22e. DATE SIGNED <b>Jan. 28, 1969</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 30, 1969</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Baptist Home Delta, Penna.</b>		23d. LOCATION (City or Town) (County) (State) <b>Fair Bluff, N.C.</b>			
24. FUNERAL DIRECTOR <b>John H. Harkins</b>		25a. DATE OF REGISTRATION <b>JAN 30 1969</b>			25b. REGISTRAR'S SIGNATURE <b>John H. Harkins</b>				

2. 8. 1. 1. 1. 1. 1.

2003 best described by

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00900

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If my delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

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00903				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				00900			
1. DECEASED NAME (Type or Print)		First Tammy	Middle Suzanne	Lost Blackburn		20. DATE KNOWN OF ESTI- DEATH MATED		Month 1 - 13	Day 149	Year M	2b. HOUR
3. SEX <b>Female</b>	4. RACE <b>White</b>	S. DATE OF BIRTH <b>Dec. 27, 1968</b>	6. AGE (in years last birthday) — YRS	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN.	2c. DATE PRONOUNCED DEAD Month <b>January 13, 1969</b>			2d. HOUR Day 19 AM
7a. BIRTHPLACE (State or foreign country) <b>GBMC Balto Co., Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Harford County,</b>					
10. CITY OR TOWN OF DEATH <b>Rocks</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Sharon Road</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>None</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13c. CITY OR TOWN <b>Harford</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Sharon Road</b>					
14. FATHER'S NAME First <b>Gary</b>		Middle <b>Woodrow</b>	Lost <b>Blackburn</b>	15. MOTHER'S MAIDEN NAME First <b>Mary</b>		Middle <b>Kathryne</b>	Lost <b>Hogan</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. -----		17. INFORMANT <b>Mary K. Blackburn</b>		ADDRESS <b>Box 122 Jarrettsville, Md. 21084</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>795 X</b>		SDII		DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
<b>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</b>											
MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?					
		21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> <b>Gerald C. Palmer</b>											
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <b>Gerald C. Palmer, M.D. 838-6116</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <b>S. Main St., Bel Air, Md. 21014</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/15/1969</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Bel Air Mem. Gardens</b>		23d. LOCATION (City or Town) <b>Bel Air, Harford</b>		(County) <b>Md.</b>	(State)		
24. FUNERAL DIRECTOR <b>Charles E. Kurtz</b>		ADDRESS <b>Jarrettsville, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 16 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles E. Kurtz</b>					

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1090.. 10901

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <b>LONNIE</b>	Middle <b>G.</b>	Last <b>BOWMAN</b>	2a. DATE OF DEATH Month <b>January</b>	Day <b>12,</b>	Year <b>1969</b>	2b. HOUR <b>12:30 A.M.</b>
3. SEX <b>Male</b>		4 RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>June 27, 1890</b>		6. AGE (In years last birthday) <b>78 yrs</b>		IF UNDER 1 YEAR MONTHS <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Harford</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Post Office</b>	
10. CITY OR TOWN OF DEATH <b>Aberdeen</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Route #2</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Mail Carrier (Ret.)</b>		13e. STREET AND NUMBER <b>Route #2, Box 131</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Harford</b>	13c. CITY OR TOWN <b>Aberdeen</b>		13d. INSIDE CITY LIMITS? <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>	13e. STREET AND NUMBER <b>Route #2, Box 131</b>		
14. FATHER'S NAME First <b>Charles</b>		Middle <b>C.</b>	Last <b>Bowman (D)</b>	15. MOTHER'S MAIDEN NAME First <b>Lucy Gorrell (D)</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO <b>220-32-3719</b>		17. INFORMANT <b>Agnes Bowman, RD. 2, Aberdeen, Md. 21001</b>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Acute Pulmonary Oedema</i>				<i>sudden</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) <i>An Auto-sclerotic Disease</i>				<i>years</i>		
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan. 1, 1969</b> , to <b>Jan. 15, 1969</b> , that (I) (we) last saw the deceased alive on <b>Jan. 1, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Ralph Horley M.D.</i>		22c. DEGREE <b>M.D.</b>		ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <b>1/13/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>J. Ralph Horley, M.D.</b>		22e. ADDRESS <b>Churchville, Maryland 21028</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>14 Jan. 69</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Smith Chapel Meth. Cemetery</b>		23d. LOCATION (City or Town) <b>Churchville</b>		(County) <b>Churchville, Md.</b>	(State)
24. FUNERAL DIRECTOR <i>Kenneth B. Lange</i>		ADDRESS <b>Tanning Funeral Home. Aberdeen, Md. 21001</b>		25a. RECED BY REGISTRAR <b>JAN 15 1969</b>		25b. REGISTRAR'S SIGNATURE <i>Horley J. Lange</i>		

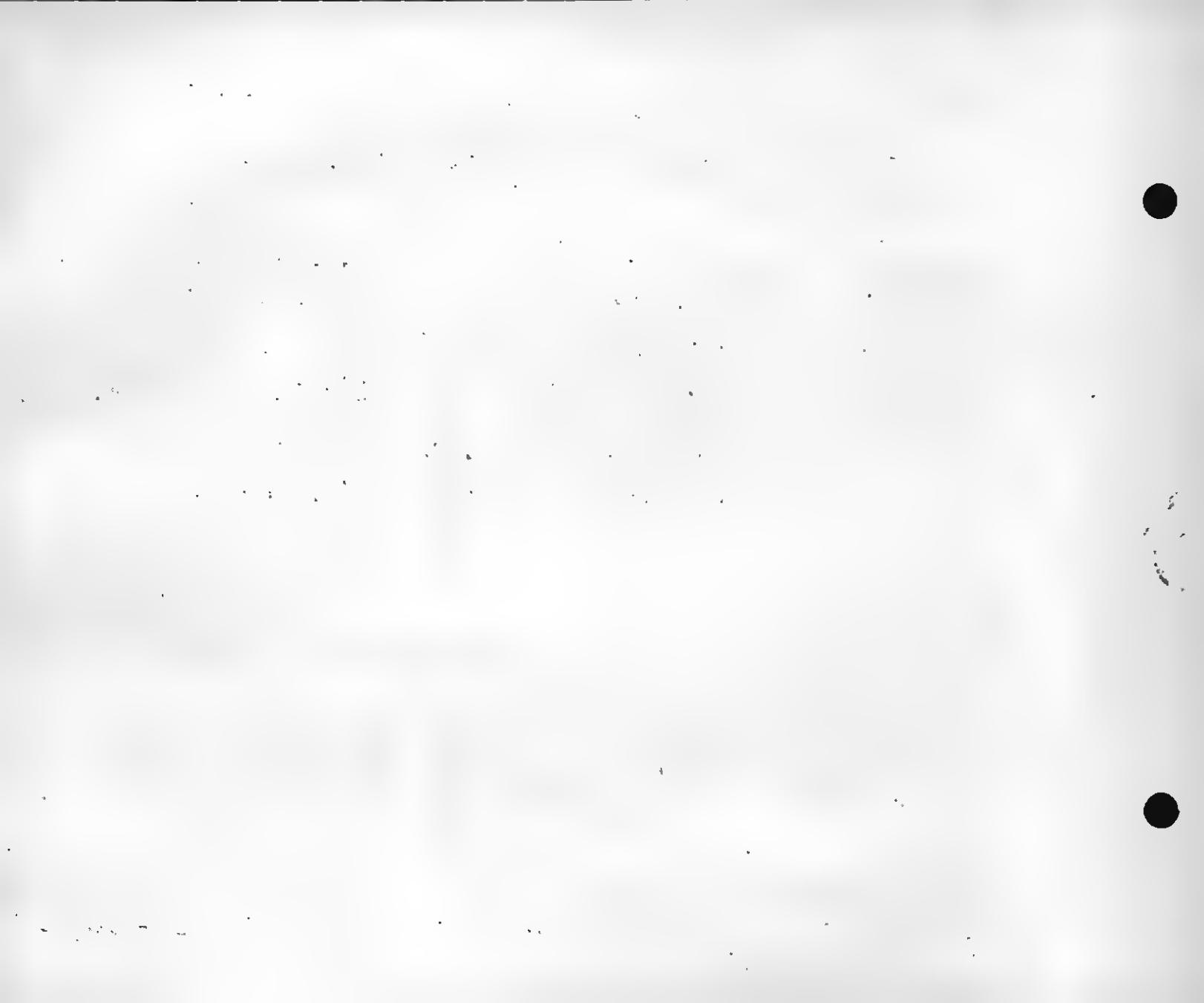


MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2) and 2 hours after death should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 DECEASED NAME (Type or print)			First <b>CHARLE</b>	Middle <b>EDWARD</b>	Last <b>BROOKS</b>	2a. DATE OF DEATH Month <b>JAN.</b> Day <b>19</b> Year <b>1969</b>	2b. HOUR <b>8A.M.</b>
3. SEX <b>MALE</b>		4 RACE <b>WHITE</b>	5. DATE OF BIRTH <b>FEB. 10, 1887</b>		6 AGE (In years lost birthday) <b>81</b> YRS.	7. UNDER 1 YEAR MONTHS DAYS	8. UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>BALTO. MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>HARFORD</b>		
10. CITY OR TOWN OF DEATH <b>HARVEDE GRACE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>620 CTSEGO ST.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>GAS STATION OPERATOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>
13c. USUAL RESIDENCE (Where deceased lived, if institutional residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>HARFORD</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	13e. STREET AND NUMBER <b>620 CTSEGO, ST.</b>			
14. FATHER'S NAME <b>CHARLES CARROLL BROOKS</b>		Middle <b>MARY JANE</b>	15. MOTHER'S MAIDEN NAME <b>ARNOLD</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b>		16b. SOCIAL SECURITY NO - A <b>252-32-9903</b>		17. INFORMANT <b>MRS. NELLIE S. BROOKS, HARVEDE GRACE MD.</b>	Address <b>620 CTSEGO ST.</b>		
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c)) <b>PART I. DEATH WAS CAUSED BY</b> <b>IMMEDIATE CAUSE (a)</b> <b>4319</b> <b>DUE TO, OR AS A CONSEQUENCE OF</b> <b>Conditions if any, which gave rise to immediate cause (a), stating the underlying cause</b> <b>(b)</b> <b>DUE TO, OR AS A CONSEQUENCE OF</b> <b>(c)</b> <b>Cerebral Hemorrhage</b> <b>Arterio-Sclerotic - Cardiac -</b> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>							
<b>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</b>							
MEDICAL CERTIFICATION		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour AM Month Day Year <b>P.M.</b> <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY <b>AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.</b>	21f. LOCATION Street or R.F.D. No <b>1</b>	City or Town <b>HARFORD</b>	County <b>MD.</b>	State <b>MD.</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 15, 1968</b> , to <b>JAN 19, 1969</b> , that (I) (we) last saw the deceased alive on <b>JAN 15, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>A.L. LEWIS</b>		DEGREE <b>M.D.</b>	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <b>JAN 20, 1969</b>	
22d. PHYSICIAN'S NAME (Type) <b>A.L. LEWIS M.D.</b>		22e. ADDRESS <b>HARVEDE GRACE, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23b. DATE <b>JAN 21 1969</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>ANGEL HILL CEM.</b>	23d. LOCATION (City or Town) <b>HARVEDE GRACE, HARFORD, MD.</b>	(County) <b>HARFORD</b>	(State) <b>MD.</b>	
24. FUNERAL DIRECTOR <b>R. Madison Mitchell, HARVEDE GRACE MD.</b>		ADDRESS <b>21075</b>	25a. DECODE BY REGISTRAR DATE <b>JAN 22 1969</b>	25b. REGISTRAE SIGNATURE <b>Judge</b>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

20903

20903

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

1. DECEASED NAME (Type or print)		First <i>Nellie E.</i>	Middle <i>Case</i>	Last <i>Case</i>	2a DATE OF DEATH Month <i>JANUARY</i>	2b HOUR Year <i>8 69</i>
3. SEX <i>Female</i>	4 RACE <i>white</i>	5 DATE OF BIRTH <i>Feb. 20-1884</i>		6 AGE (In years lost birthday) <i>89</i>	7f UNDER 1 YEAR MONTHS <i>0</i>	7f UNDER 24 HRS HOURS <i>0</i>
7a BIRTHPLACE (State or foreign country) <i>Baltimore, Md., U.S.A.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <i>[Signature]</i>	9 COUNTY OF DEATH <i>Harford</i>	10c INSIDE CITY LIMITS? <i>YES</i>
10 CITY OR TOWN OF DEATH <i>Havre de Grace</i>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Memorial Hospt.</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md.</i>		13b CITY OR TOWN <i>Harford</i>		13c CITY OR TOWN <i>Harford</i>		13e STREET AND NUMBER <i>140 St. John ST</i>
14 FATHER'S NAME First <i>Nelson Case</i>		Middle <i></i>	Last <i></i>	15 MOTHER'S MAIDEN NAME First <i>Elizabeth Polley</i>		Middle <i></i>
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b SOCIAL SECURITY NO <i>unls</i>		17 INFORMANT <i>Nelson Ballard</i>		18b MAX. AGE INTERVA. BETWEEN ONSET AND DEATH <i>4 hours</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>4</i> (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause) <i>+</i> lost.		DUE TO, OR AS A CONSEQUENCE OF <i>Deute pulmonary edema</i>				18c <i>4 hours</i>
(b) <i>ASCD</i>		DUE TO, OR AS A CONSEQUENCE OF				18d <i>years</i>
(c) <i></i>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No		City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <i>1-6</i> , 19 <i>69</i> , to <i>1-8</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>1-8</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death						
22b. SIGNATURE <i>A.W. Grigoleit MD</i>		DEGREE <i></i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>1/8/69</i>
22d. PHYSICIAN'S NAME (Type) <i>A.W. Grigoleit</i>		22e ADDRESS <i>Havre de Grace, Md.</i>				
23a BURIAL, CREMATION, REMOVAL (Specify) <i></i>		23b DATE <i>1/1/69</i>	23c NAME OF CEMETERY OR CREMATORIUM <i>Angel Hill</i>		23d LOCATION (City or Town) (County) <i>Havre de Grace, Md.</i>	(State)
24. FUNERAL DIRECTOR <i>Young, Inc.</i>		ADDRESS <i>100 South Main St.</i>	25a REC'D BY REGISTRAR DATE <i>JAN 14 1969</i>		25b REGISTERED & INDEXED BY <i>Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

33904

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First <b>Roland</b>	Middle <b>W</b>	Last <b>Clark</b>	2a. DATE OF DEATH Month <b>Jan</b>	Day <b>2</b>	Year <b>1969</b>	2b. HOUR <b>2330 M</b>				
3. SEX <b>Male</b>		4. RACE <b>Cau</b>		5. DATE OF BIRTH <b>9 Jun 36</b>		6. AGE (in years last birthday) <b>32 yrs.</b>		IF UNDER 1 YEAR MONTHS <b>00</b>	IF UNDER 24 HRS. DAYS <b>00</b>	HOURS <b>00</b>	MIN. <b>00</b>	
7a. BIRTHPLACE (State or foreign country) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Harford</b>						
10. CITY OR TOWN OF DEATH <b>Edgewood</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>6533 B Hawthorne Drive</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Soldier</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Edgewood</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>6533 B Hawthorne Drive</b>				
14. FATHER'S NAME First <b>Allen</b>		Middle <b>Clark</b>	Last	15. MOTHER'S MAIDEN NAME First <b>Margaret</b>		Middle <b>Hamilton</b>	Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>1954-1969</b>		17. INFORMANT <b>Personnel Office, Edgewood, Md.</b>		Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Interstitial pneumonitis diffuse, bilateral  441.0 DUE TO, OR AS A CONSEQUENCE OF (b) Cardiomegaly with right and left ventricular DUE TO, OR AS A CONSEQUENCE OF hypertrophy (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State		
22a. I certify that (I) (not hospital) attended the deceased from <b>2 Jan</b> , 1969, to <b>2 Jan</b> , 1969, that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>John M. Dent CPT MC</i>		22c. DATE SIGNED <b>3 Jan 69</b>		22d. PHYSICIAN'S NAME (Type) <b>JOHN M DENT, CPT, MC</b>		22e. ADDRESS <b>Edgewood Dispensary, Edgewood Ars., Md.</b>						
23a. BUR. A. CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1-7-69</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Post Cemetery</b>		23d. LOCATION (City or Town) <b>Aberdeen Proving Gnd.</b>		(County) <b>Md.</b>		(State)		
24. FUNERAL DIRECTOR <i>Grant F. Foyen</i>		ADDRESS <i>1001 North East St.</i>		25a. REG'D. BY/REGISTRAR <b>JAN 1969</b>		25b. REGISTRAR'S SIGNATURE <i>Wm. J. Judge</i>						



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be signed within 24 hours after death.

**2**  
Page 4 may be retained by the hospital or attending physician.

**3** **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print) <b>Cora</b>			First	Middle	Last	2a. DATE OF DEATH Month Day Year <b>16 69 940 AM</b>	2b. HOUR <b>940 AM</b>
3 SEX <b>F</b>	4. RACE <b>W</b>	S. DATE OF BIRTH <b>June 1, 1875</b>	5. AGE (In years last birthday) <b>78 yrs</b>		6. AGE (In years last birthday) <b>78 yrs</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE State or foreign country <b>Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Hanford</b>		
10 CITY OR TOWN OF DEATH <b>Hanford, Wash.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Hanford Memorial Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Pennsyl.</b>		13b. COUNTY <b>York</b>		13c. CITY OR TOWN <b>Delta</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>RD 2</b>	
14 FATHER'S NAME First <b>Unknown</b>		Middle	Last	15 MOTHER'S MAIDEN NAME First <b>Belle</b>		Middle	Last <b>Cornett</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO <b>227-05-6038</b>		17 INFORMANT <b>Stephen F. Comer, 111 H 2 11 Ha 1a.</b>	Address <b>11n</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)  Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Cecile Coronay Thimbyin</b>		DUE TO, OR AS A CONSEQUENCE OF <b>Generalized arteriosclerosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <b>While at work</b>	21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19 P.M. 19 69</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>At home farm, street, factory OFFICE BUILDING ETC</b>	21f. LOCATION Street or RFD No <b>City or Town County State</b>				
22a. I certify that (I) (this hospital) attended the deceased from <b>11 11 1968</b> to <b>1 16 1969</b> , that (I) (we) last saw the deceased alive on <b>11 16 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	22b. SIGNATURE <b>Dudley Phillips</b>		DEGREE <b>PHYS</b>	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE/SIGNED <b>11/17/69</b>
22d. PHYSICIAN'S NAME (Type) <b>Dudley Phillips</b>	22e. ADDRESS <b>Washington Md 21031</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Jan. 19, 1969</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Nebo Cemetery</b>	23d. LOCATION (City or Town) <b>Delta, York Co.</b>	(County) <b>York Co.</b>	(State) <b>Pennsyl.</b>		
24. FUNERAL DIRECTOR <b>John H. Harkins</b>	ADDRESS <b>Delta, Pa.</b>	25a. REGISTRATION STAR <b>JAN 21 1969</b>	25b. REGISTRAR'S SIGNATURE <b>George J. George</b>				



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

Item 1, Film 409 2/5/69 cac

409

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First John	Middle H.	Last Darney	2a. DATE OF DEATH Month Day Year 1 31 69	2b. HOUR 8 AM
3. SEX M	4. RACE W	5. DATE OF BIRTH 9-13-1912	6. AGE (In years last birthday) 56 yrs	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS HOURS MN
7a. BIRTHPLACE (State or foreign country) Md	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Hartford		
10. CITY OR TOWN OF DEATH Havre de Grace	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hartford Memorial	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Carpenter	12b. KIND OF BUSINESS OR INDUSTRY 2105		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.	13c. CITY OR TOWN Hartford	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 25 15 Jerusalem Rd.		
14. FATHER'S NAME First Frederick	Middle Charles	Last Darney	15. MOTHER'S MAIDEN NAME Porthea	16. Address Mrs. Abel Darney 2515 Jerusalem Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Generalized Carcinomatosis</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>11/02</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Retro-peritoneal mass -</i> (c) <i>Etiology undetermined</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH B.T. NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 19a. DATE OF OPERATION 1/17/69					
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Obstruction &amp; Hemorrhage</i>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> If either, notify medical examiner	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)			
21d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1-6, 1969, to 1-31, 1969, that (I) (we) last saw the deceased alive on 1/31/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Charles J. Foley Jr.</i>	22c. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. PHYSICIAN'S NAME (Type) CHARLES J. FOLEY JR.	22e. ADDRESS HAURE DE GRACE, MD	22f. DATE SIGNED FEB 5 1969	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-2-1969	23c. NAME OF CEMETERY OR CREMATORIUM St. Stephens Cemetery	23d. LOCATION (City or Town) Bradshaw	(County) Baltimore	(State) Md.
24. FUNERAL DIRECTOR Lassahn Funeral Home	ADDRESS 7401 Belair Road 21236	25a. REC'D BY REGISTRAR DATE FEB 5 1969	25b. REGISTRAR'S SIGNATURE <i>Charles J. Foley Jr.</i>		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

00907

30910

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 DECEASED NAME (Type or print)	First <b>CLARENCE</b>	Middle <b>E.</b>	Last <b>DORSEY</b>	2a. DATE OF DEATH Month <b>January</b>	Day <b>18</b>	Year <b>1969</b>	2b. HOUR <b>8:25 AM</b>
3. SEX <b>Male</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH <b>August 31, 1890</b>		6. AGE (In years last birthday) <b>78</b>		IF UNDER 24 HRS MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Harford</b>			
10. CITY OR TOWN OF DEATH <b>Aberdeen</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Bush Chapel Road</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Baggage Agent (Ret.)</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Harford</b>	13c. CITY OR TOWN <b>Aberdeen</b>	13d. INSIDE CITY LIMITS? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>	13e. STREET AND NUMBER <b>Bush Chapel Road</b>			
14. FATHER'S NAME First <b>Fred</b>	Middle <b>Dorsey</b>	Lost <b>(D)</b>	15. MOTHER'S MAIDEN NAME First <b>Unknown</b>			Middle	Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>717-07-5504</b>	17. INFORMANT <b>Margaret Dorsey, Aberdeen, Maryland</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Respiratory Failure</b> 4/24 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Bronchiolitis with Pulmonary Emphysema</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Cardiovascular disease</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Gastroduodenitis with Intractable Hiccough</b> (b) <b>Cerebral Thrombosis with Left Hemi paresis</b>							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b>19</b> P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>9/26</b> , 19 <b>64</b> , to <b>1/18</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1/18</b> 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>George T. Stansbury, M.D.</i>		DEGREE <b>M.D.</b>	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <b>1/21/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>George T. Stansbury, M.D.</b>		22e. ADDRESS <b>569 Revolution St. Havre de Grace, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>22 Jan. 69</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Calvary Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Aberdeen, Harford Co. Maryland</b>		
24. FUNERAL DIRECTOR Tarring Funeral Home, Aberdeen, Md. 21001		ADDRESS		25a. REC'D BY REGISTRAR <b>AN 23 1969</b>	25b. REC'D BY CLERK <i>George T. Stansbury</i>		



1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00913

10908  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
Harford Maryland		a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Hill		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Hill	
c. LENGTH OF STAY IN 1b 26 yrs.		d. STREET ADDRESS Jarrettsville Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Jarrettsville Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sarah Middle Jane Last Fender		4. DATE OF DEATH Month January Day 5 Year 1969	
5. SEX Female White 6. COLOR OR RACE Widowed 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH March 27, 1882 9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Sparta, N. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Melvin Edwards		14. MOTHER'S MAIDEN NAME Martha Crouse	
15. WAS DECEASED EVER IN U.S. ARMEED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 017-54-4336 INFORMANT Address Box 56	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 471X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 days	
(b) Epidemic Flu		5 days	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury In Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 29, 1951, to Jan. 5, 1969, that (I) (we) last saw the deceased alive on Jan. 5, 1969, and that death occurred at 9 P.M. from the causes and on the date stated above.		22a. SIGNATURE Robert Barthel	
22b. DATE SIGNED Jan. 6/69			
22c. PHYSICIAN'S NAME (Type) Robert Barthel		22d. ADDRESS Forest Hill, Maryland 105 W. Jarrettsville Rd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/8/1969	
23c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion		23d. LOCATION (City, town or county) (State) Fountain Green, Md.	
24. FUNERAL DIRECTOR Charles E. Kurtz Jarrettsville, Md.		25a. REC'D BY REGISTRAR JAN 7: 1969	
AOORESS		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

00909

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <b>Carrie Eleanor</b>	Middle <b>Fox</b>	Last <b>Fox</b>	2a DATE OF DEATH Month <b>JANUARY 22 1969</b>	2b HOUR Year <b>2 P.M.</b>			
3. SEX <b>Female</b>	4. RACE <b>White</b>	S DATE OF BIRTH <b>8/22/1893</b>	6 AGE (In years lost birthday) <b>73 yrs</b>	IF UNDER MONTHS <b>0</b>	YEAR <b>0</b>	IF UNDER HOURS <b>0</b>	24 HRS <b>0</b>	
7a BIRTHPLACE (State or foreign country) <b>Md</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	9. COUNTY OF DEATH <b>Harford</b>					
10 CITY OR TOWN OF DEATH <b>Havre de Grace</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Harford Mem Hosp</b>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>			12b KIND OF BUSINESS OR INDUSTRY <b>Same</b>			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md</b>	13b. COUNTY <b>Harford</b>	13c. CITY OR TOWN <b>Havre de Grace</b>	13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e STREET AND NUMBER <b>658 Otsego St.</b>				
14 FATHER'S NAME <b>Kenwood L.</b>	Middle <b>Heedam</b>	Last <b>Carrive</b>	15 MOTHER'S MAIDEN NAME First <b>Ella</b>	Middle <b>Boyd</b>	Last <b>Abraham</b>	Address <b>1208 Pennsylvania</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>	16b SOCIAL SECURITY NO <b>Yes</b>	17 INFORMANT <b>Mr Fred Fox</b>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>72 hrs.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Cardiovascular Disease</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) <b>Hypertension and Calcific Aortic Stenosis</b>								
19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at play <input type="checkbox"/>	21e PLACE OF INJURY (At Home, Farm, Street, Factory, OFFICE, BUILDING ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State			
22a. I certify that (I) (this hospital) attended the deceased from <b>1-21, 1969</b> , to <b>1-22, 1969</b> , that (I) (we) last saw the deceased alive on <b>1-22, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Dante U. Monakil, M.D.</b>	DEGREE <b>M.D.</b>	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <b>1-22-69</b>			
22d. PHYSICIAN'S NAME (Type) <b>DANTE U. MONAKIL, M.D.</b>	22e ADDRESS <b>211 N Union Ave. Havre de Grace, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL, (Specify) <b>Burial</b>	23b. DATE <b>1/25/69</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Angel Hill Cemetery</b>	23d. LOCATED ON (City or Town) <b>Havre de Grace Harford Md.</b>	County <b>Harford</b>	(State) <b>Md.</b>			
24. FUNERAL DIRECTOR <b>Funeral Director, Havre de Grace, Md.</b>	ADDRESS <b>111 Union Ave., Havre de Grace, Md.</b>	25a. REGISTRATION NUMBER <b>JAN 24 1969</b>	25b. REGISTRATION SIGNATURE <b>James J. Judge</b>					



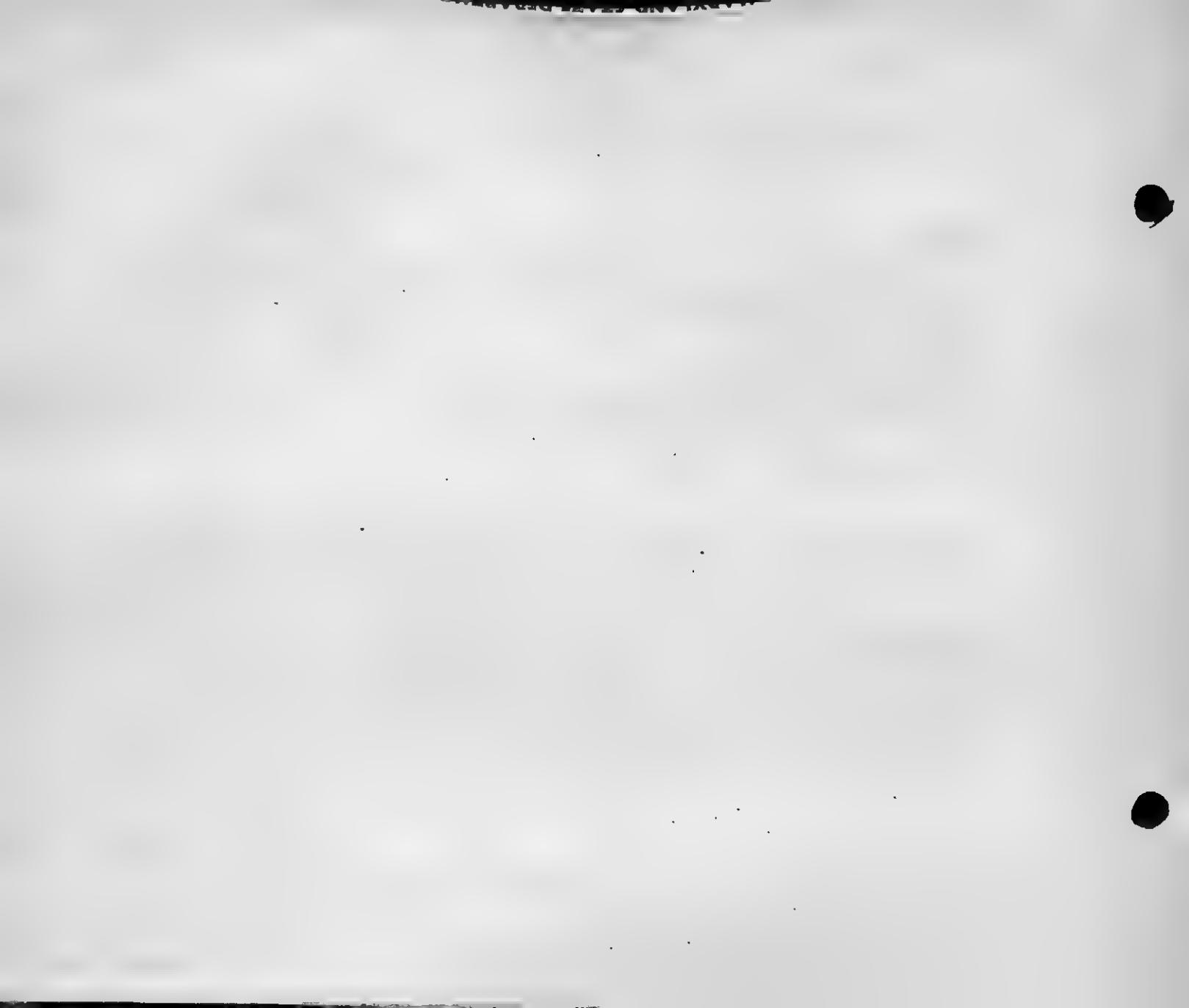
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the physician or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

1 00910		2 00910	
<p><b>1. PLACE OF DEATH</b>            a. COUNTY <b>HARFORD</b></p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RORAL - DARLINGTON</b></p> <p>c. LENGTH OF STAY IN HOSPITAL <b>LIFE</b></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>R.D #1 Box 115</b></p>		<p><b>2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)</b>            e. STATE <b>MD</b>            b. COUNTY <b>HARFORD</b></p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RORAL - DARLINGTON</b></p> <p>d. STREET ADDRESS <b>R.D. #1 Box 115</b></p>	
<p><b>3. NAME OF DECEASED (Type or print)</b>            First <b>MARY</b> Middle <b>ANDREW</b> Last <b>GEORGE</b></p> <p><b>4. DATE OF DEATH</b> JAN. 7 1969</p>		<p><b>5. SEX</b> FEMALE <b>6. COLOR OR RACE</b> WHITE <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> FEB. 5, 1925</p> <p><b>9. AGE (in years) IF UNDER 1 YEAR</b> 43 yrs. <b>IF UNDER 24 HRS.</b> Months Days Hours Min.</p>	
<p><b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>FARMER</b></p>		<p><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>FARM</b></p>	
<p><b>11. BIRTHPLACE</b> (County &amp; State, or foreign country) <b>MD</b></p>		<p><b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b></p>	
<p><b>13. FATHER'S NAME</b> <b>JOHN EVANS GEORGE</b></p>		<p><b>14. MOTHER'S MAIDEN NAME</b> <b>ANNIE J. ANDREW</b></p>	
<p><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b></p>		<p><b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <b>ANNIE T. GEORGE</b> Address <b>Bok 115 DARLINGTON, MD RD #1</b></p>	
<p><b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)</p> <p><b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <b>1926</b>  <b>DUE TO</b> <b>Bronchopneumonia</b>  <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.</b> <b>(b)</b> <b>Pulmonary Metastases</b>  <b>(c)</b> <b>Melanosarcoma - on the back</b></p>		<p><b>INTERVAL BETWEEN ONSET AND DEATH</b>  <b>1 week</b>  <b>3-6 mos</b>  <b>2 1/2 yrs</b></p>	
<p><b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)</b></p>			
<p><b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify MEDICAL EXAMINER)</p>		<p><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)</p>	
<p><b>20c. TIME OF INJURY</b> Month, Day, Year            Hour a.m. <b>Month</b> <b>Day</b> <b>Year</b>            p.m. <b>19</b></p>		<p><b>20d. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20e. (City or town)</b> <b>(County)</b> <b>(State)</b></p>	
<p><b>21. I certify that (I) (this hospital) attended the deceased from ..... 1968 to ..... 1969, that (I) (we) last saw the deceased alive on ..... 11/20 1968 and that death occurred at ..... M, from the causes and on the date stated above.</b></p>		<p><b>22a. SIGNATURE</b> <b>J.H. Sadowsky</b></p>	
<p><b>22c. PHYSICIAN'S NAME (Type)</b> <b>W.H. SADOWSKY</b></p>		<p><b>22b. DATE SIGNED</b> <b>1/8/69</b></p>	
<p><b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b> <b>23b. DATE THEREOF</b> <b>JAN 10, 1969</b></p>		<p><b>23c. NAME OF CEMETERY OR CREMATORIUM</b> <b>DARLINGTON CEM.</b> <b>23d. LOCATION (City, town or county)</b> <b>DARLINGTON HARFORD Co. MD.</b> <b>(State)</b></p>	
<p><b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>R. Madison Mitchell</b> <b>ADDRESS</b> <b>HARFORD, MD.</b></p>		<p><b>25a. RACED BY REGISTRAR</b> <b>REG. NO. 19</b> <b>DATE</b> <b>1969</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>James J. Geage</b></p>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10916

10912

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First <i>SHERMAN</i>	Middle <i>E.</i>	Last <i>GILBERT</i>	20. DATE OF DEATH Month <i>January</i> Day <i>2</i> , Year <i>1968</i>	2b. HOUR <i>10:30 A.M.</i>			
3 SEX <i>Male</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>DEC 7, 1906</i>		6 AGE (in years last birthday) <i>62</i> YRS.	F UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS. DAYS <i>0</i>	HOURS <i>0</i>	MIN <i>0</i>	
7a BIRTHPLACE (State or foreign country) <i>ILL</i>	7b CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>HARFORD</i>					
10. CITY OR TOWN OF DEATH <i>Hause de Grace / HARFORD Memorial</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of work ing life, even if retired) <i>MAINTENANCE</i>		2b. KIND OF BUSINESS OR INDUSTRY <i>U.S. GOV.</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MD</i> COUNTY <i>Cecil</i>		13c. CITY OR TOWN <i>Rising Sun</i>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER				
14. FATHER'S NAME First <i>EDWARD</i> Middle <i>GILBERT</i> Lost		15. MOTHER'S MAIDEN NAME First <i>LARA</i> Middle <i>CARTER</i> Lost							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? <i>NO</i>		16b. SOCIAL SECURITY NO <i>578-05-2934</i>		17. INFORMANT		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>4109 Coronary Occlusion</i> (b) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE OR CONDITION G VEN IN PART 1(o)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <i>January 2, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Dante U. Monacic, M.D.</i>		22c. DEGREE ATTENDING PHYS		<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22d. DATE SIGNED <i>1/2/69</i>			
22d. PHYSICIAN'S NAME (Type) <i>DANTE U. MONACIC, M.D.</i>		22e. ADDRESS <i>211 N. Union Ave. Havre de Grace, Md.</i>							
23a. BURIAL/CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>11/5/69</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>HOPEWELL</i>		23d. LOCATION (City or Town) <i>POTTER DEPOSIT, CECIL, MD.</i>			(County) <i>Cecil</i> (State) <i>MD.</i>
24. FUNERAL DIRECTOR <i>RALPH M REED</i>		ADDRESS <i>Ralph M Reed</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 6 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month	1 Day	31 Year	69	12 hrs 09 min
3 SEX		4 RACE	Mary Grove Graeser		S. DATE OF BIRTH 12 March 1909		2b. HOUR		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Harford		6 AGE (In years last birthday) 59 yrs.	
10 CITY OR TOWN OF DEATH Harve de Grace		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial		12a. USUAL OCCUPATION (Kind of work done during most of work no. I.e., even if retired) Beautician		12b. KIND OF BUSINESS OR INDUSTRY Beauty Shop			
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Md		13b. CITY OR TOWN Cecil		13c. INS DE CITY, M.T.S? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 19 High St.			
14. FATHER'S NAME John Earl Tyson		15. MOTHER'S MAIDEN NAME Elizabeth Tash							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO 218-09-0978		17. INFORMANT Oliver Wm. Graeser, Port Deposit, Md.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1978 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Carcinoma of Liver				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days?			
(b)		DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town	County		
22a. I certify that (I) (this hospital) attended the deceased from 1-30, 1969, to 1-31, 1969, that (I) (we) last saw the deceased alive on 1-31, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE A.W. Grigoleit MD		DEGREE	ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 1/31/69			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS A.W. GRIGOLEIT M.D. HARVE de GRACE				Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5 Feb. 69		23c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cemetery, Ft Myer,		23d. LOCATION (City or Town) (County) (State) Virginia			
24. FUNERAL DIRECTOR Tarring Funeral Home, Aberdeen, Md. 21001		ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 4 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



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20919  
1313

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death cert ficer be exercised within 24 hours of death.

**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First <i>John</i>	Middle <i>Clinton</i>	Last <i>Graybeal</i>	2a DATE OF DEATH Month <i>1</i>	Day <i>30</i>	Year <i>69</i>	2b HOJR <i>10AM</i>	
3 SEX <i>M</i>	4 RACE <i>W</i>	5 DATE OF BIRTH <i>Nov. 3, 1883</i>		6 AGE (in years last birthday) <i>85</i>	IF UNDER MONTHS <i>0</i>	YEAR DAYS <i>0</i>	IF UNDER 24 HRS HOURS <i>0</i>	MIN <i>0</i>	
7a BIRTHPLACE (State or foreign country) <i>N.E.</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	9. COUNTY OF DEATH <i>Harford</i>	9. COUNTY OF DEATH <i>Harford</i>			
10 CITY OR TOWN OF DEATH <i>Havre de Grace</i>		11 NAME OF HOSPITAL OR INST TUT ON (If not in hospital g or street address) <i>Harford Memorial</i>		12a USUAL OCCUPATION (Kind of work done during most al working life, even if retired) <i>Farmer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md</i>		13b CITY OR TOWN <i>Harford</i>		13d INSIDE CTY JNTS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER <i>Rt #1 Box 345</i>				
14 FATHER'S NAME First <i>Peter</i>		Middle <i>Graybeal</i>	Last <i>Katherine Hardin</i>	15 MOTHER'S M AIDEN NAME First Middle Last <i>Katherine Hardin</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown <i>No</i>		16b. SOCIAL SECURITY NO <i>220-34-6978</i>		17. INFORMANT <i>Mrs. Blanche E. T. Graybeal</i>	Address <i>RD #1 Box 345 Fallston, Md. 21047</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>600x</i>		DUE TO, OR AS A CONSEQUENCE OF <i>Bacteremia</i>		DUE TO, OR AS A CONSEQUENCE OF <i>Pyelonephritis &amp; Cystitis</i>		DUE TO, OR AS A CONSEQUENCE OF <i>Bilious Prostate Hyper trophy</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>lost</i>									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>Arteriosclerosis Cardiomegaly Disease - Senility</i>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work		21e PLACE OF INJURY (AT HOME FARM STREET, FACTORY OFFICE BUILDING ETC) <i>Bel Air Mem. Gardens</i>		21f. LOCATION Street or R.F.D. No <i>811 North Union Ave</i>	City or Town <i>Bel Air</i>	County <i>Harford</i>	State <i>Maryland</i>		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>Charles E. Kurtz</i>		D.GRS ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c DATE SIGNED <i>1/30/69</i>						
22d. PHYSICIAN'S NAME (Type) <i>D.U. MONAKIL</i>		22e ADDRESS <i>811 North Union Ave Bel Air</i>							
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>2/2/1969</i>	23c NAME OF CEMETERY OR CREMATORIUM <i>Bel Air Mem. Gardens</i>		23d LOCATION (City or Town) <i>Bel Air, Harford, Maryland</i>	(County) <i>Harford</i>	(State) <i>Maryland</i>		
24 FUNERAL DIRECTOR <i>Charles E. Kurtz</i>		ADDRESS <i>Jarrettsville, Md. 21084</i>		25a REG'D BY REGISTRAR <i>FEB 4 1969</i>	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 2120100913  
00314

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

Any delay is  
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to  
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the State Department of  
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of  
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.  
 5 may be retained for your files

1 DECEASED NAME (Type or Print)	First <b>JOSEPH</b>	Middle <b>EDWIN</b>	Last <b>GREEN</b>	2a DATE KNOWN Month Day Year DEATH EST'D. <b>JAN 24 1969</b>	2b HOURS M <b>A</b>				
3 SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5 DATE OF BIRTH <b>FEB 1, 1908</b>	6 AGE (In years last birthday) <b>60 YRS</b>	IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS DAYS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b>	2c DATE PRONOUNCED DEAD Month Day Year <b>JAN 24 1969</b>	2d HOURS M <b>A</b>	
7a BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <b>HARFORD</b>						
10 ID CITY OR TOWN OF DEATH <b>JARRETTSVILLE</b>	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>FURNACE Rd</b>			12a. USUAL OCCUPATION (Kind of work done during or at working life, even if retired) <b>HORSE-TRAINER-OWNER</b>			12b KIND OF BUSINESS OR INDUSTRY <b>RACING</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution before admission) STATE <b>Md</b>	13b. COUNTY <b>PRINCE GEORGES</b>	13c. CITY OR TOWN <b>LAUREL</b>	13d. INSIDE CITY LIMITS? <b>YES</b>	13e STREET AND NUMBER <b>#1832</b>	13f ADDRESS <b>13803 BRIARWOOD DRIVE LAUREL, MD 20810</b>				
14 FATHER'S NAME First <b>FRANK</b>	Middle <b>GREEN</b>	Last <b>UNKNOWN</b>	15 MOTHER'S MAIDEN NAME First <b>EDNA M. GREEN</b>	Middle <b>LAUREL</b>	Last <b>MD 20810</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16b SOCIAL SECURITY NO (If yes give war or dates of service) <b>115-14-8620</b>	17 INFORMANT <b>MRS. EDNA M. GREEN</b>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
18 CAUSE OF DEATH (Enter on a line cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <b>9520</b> IMMEDIATE CAUSE (a) <b>CARBON MONOXIDE ASPHYXIATION</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>SUICIDE</b> DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR AM P.M. <b>JAN 24, 1969</b>	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) <b>HOSE EXHAUST PIPE TO CAR</b>							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (At home, farm, street, factory, office building etc.) <b>CAR - FURNACE Rd</b>	21f LOCATION Street or R.F.D. No <b>FURNACE</b> or Town <b>JARRETTSVILLE</b> County <b>Harford</b> State <b>Md</b>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Philip W. Heuman</i>	MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED <b>JAN 24, 1969</b>			
EXAMINER'S NAME (Type) <b>PHILIP W. HEUMAN, M.D.</b>	EXAMINER'S ADDRESS (Street, city, town or county) <b>BEL AIR, MD.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	REGISTRAR'S SIGNATURE <i>James J. Young</i>					
23a. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>1/27/1969</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>WARRENTON</b>	23d. LOCATION (City or Town) <b>WARRENTON, FAIRFAX, VA.</b>	(County) <b>FAIRFAX</b>	(State) <b>VA.</b>				
24 FUNERAL DIRECTOR <b>CHARLES E. KURTZ JARRETTSVILLE, MD</b>	ADDRESS		25a. REC'D BY REGISTRAR <b>JAN 27 1969</b>	25b. REGISTRAR'S SIGNATURE <i>James J. Young</i>					



Item 21 Film 409  
2-10-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

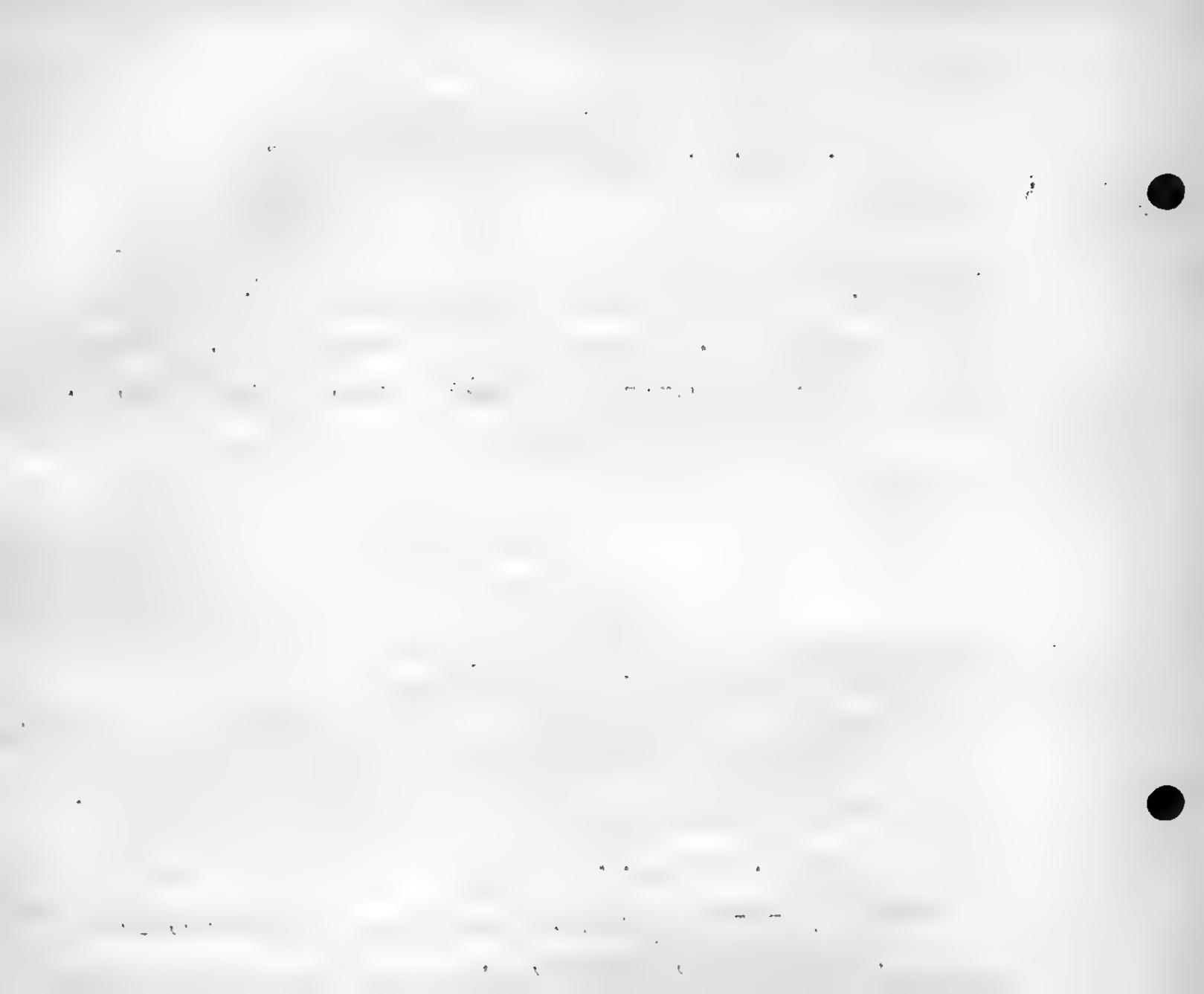
00920 00915

FOR STATE  
HEALTH DEPT.

any delay is  
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give <sup>PMJ</sup> 2, and 3 to  
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMJ. Page  
5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of  
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)				First	Middle	Last	20. DATE KNOWN OF ESTI. DEATH MATED	Month	Day	Year	26. HOUR		
Mary				Ellen	Hasson		1-	22	-	1969	M		
3 SEX	4 RACE	S DATE OF BIRTH	16 AGE (in years last birthday)	F UNDER MONTHS	YEAR DAYS	17 UNDER 24 HRS HOURS MIN.	2c DATE PRONONCED DEAD Month				2d HOUR		
Female	Cau.	Dec. 15, 1886	82 yrs				January	22	, 1969	12 P.M.			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. COUNTY OF DEATH							
Maryland		USA		<input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED		Harford							
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Havre de Grace		Harford Memorial Hospital				House Wife							
13a U.S.A. RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER					
Md.		Cecil		Port Deposit		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		128 S. Main					
14 FATHER'S NAME				First	Middle	Last	15. MOTHER'S MAIDEN NAME				First	Middle	Last
John				W.	Found		Hannah				E.	Murphy	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO (If yes give name or dates of service)		17 INFORMANT		ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No				219-18-9505		Hospital Records, Havre de Grace, Md.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fracture Right Femur DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?					
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day Year HOUR A.M. P.M.	Nov. 1968		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No.		City or Town		County	State		
				Home		Port Deposit		Cecil		Md.			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Gerald C. Palmer												CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.												ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
M.D.												DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ADDRESS (Street, city, town, or county)												Bel Air, Md.	
												22b. DATE SIGNED 1-23-69	
23a BURIAL, CREMATION REMOVED (Specify)				23b DATE	23c NAME OF CEMETERY OR CREMATORIALy				23d LOCATION (City or Town)	(County)	(State)		
Burial				1-25-69	Asbury Cemetery				Port Deposit	Cecil	Md.		
24 FUNERAL DIRECTOR				ADDRESS				25a REGISTRATION STAR	25b. REGISTRAR'S SIGNATURE				
Lee A. Patterson & Son, Perryville, Md.								FEB 13 1969					
								DATE					



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1		0092-		1		3318	
1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month	2b. HOUR Doy Year	2b. HOUR YRS. MONTHS DAYS HOURS MIN
Charles Wintor Hudler				Hudler	January 15 1969	955 AM	
3. SEX		4 RACE		5. DATE OF BIRTH	6. AGE (in years (less birthday))		
Male		White		Feb. 6, 1893	75		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH		
N.C.		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Hanford		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Havre de Grace		Hartford Mem. Hosp.		Farmer		Farm	
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER		
Md.		Cecil	Noth East	NO	Box 106 RD #1		
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle
James		W.	Hudler	ELIZABETH	—	Blevens	Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes no, if unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS	
No		318-18-1240		Mrs. Chas. W. Hudler		North East, R.D.	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
5 days							
14 days							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) pneumonitis							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
(b) cerebrovascular accident							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from 12-27-1968, to 15 JAN 1969, that (I) (we) last saw the deceased alive on 15 JAN 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		Neil R. Taylor		DEGREE	ATTENDING PHYS	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type)		Neil R. Taylor MD		22e. ADDRESS		22f. DATE SIGNED	
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCAT ON (City or Town)	(County) (State)
BURIAL		1-18-1969		Conowingo Baptist & Conowingo		Leil Md.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Amon E. McPherson		Rising Sun, Md.		JAN 17 1969		Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00917

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3 Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)	First	Middle	Last	2a. DATE KNOWN OF EST. DEATH MATED	Month	Day	Year	2b. HOUR
MICHAEL -- KOZUB				Jan. 29 1969				
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS			
Male	White	June 30, 1893	75 yrs	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH	2c. DATE PRONOUNCED DEAD Month	DOA Year	2d. HOUR		
Austria	USA	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Harford	Jan.	29 1969	4 PM		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY		
Havre de Grace	DOA - Harford Memorial Hospital				Machinist	Shipbldg.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER				
Md.	Harford	Abingdon	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	320 Hooker Mill Road				
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
Alexander -- Kozub				Mary	Skovranek			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT	ADDRESS Abingdon, Md.					
Yes	WVI	Michael J. Kozub, 320 Hooker Mill Road,						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY								
IMMEDIATE CAUSE (a) <i>Arterio sclerotic CV disease</i>								
4124 DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a) } stating the underlying cause } last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF								
(c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				2d. AUTOPSY?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Gerald C. Palmer</i>		EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED Jan. 30, 1969
ADDRESS (Street, city, town, or county) Bel Air, Md.								
23a. BURIAL, CREMATION REMOVAL (Specify)	23b. DATE Feb. 1, 1969	23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens				23d. LOCATION (City or Town) Bel Air	(County) Harford	(State) Md.
24. FUNERAL DIRECTOR	ADDRESS Howard K. McComas & Son, Abingdon, Md.				25a. REC'D. BY REGISTRAR DATE FEB 3 1969	25b. REC'D. BY SALES PERSON DATE		



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

00918

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and ~~completes~~ filed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>EDWARD DAVID Labrenz</i>	Middle <i></i>	Last <i></i>	2d. DATE OF DEATH Month <i>JAN</i>	Day <i>24</i>	Year <i>1969</i>	2b. HOUR <i>11:30 AM</i>		
3 SEX <i>Male</i>	4. RACE <i>white</i>	5 DATE OF BIRTH <i>October 7, 1874</i>	6 AGE (in years last birthday) <i>74</i>	7e. UNDER 1 YEAR MONTHS <i></i>					
7a. BIRTHPLACE (State or foreign country) <i>Pittsburgh, Pennsylvania</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>HARFORD Co.,</i>	7f. UNDER 24 HRS MONTHS <i></i>					
10. CITY OR TOWN OF DEATH <i>Havre de Grace</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>HARFORD Memorial Hosp.</i>	12a. OCCUPATION (Kind of work done during most of working life, even if retired) <i>Installation</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Elevator</i>						
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>MARYLAND</i>	13b. CITY OR TOWN <i>HARFORD Bel Air</i>	13c. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET AND NUMBER <i>102 W. Belcrest Rd.</i>						
14 FATHER'S NAME First <i>August</i>	Middle <i>LABRENZ</i>	15 MOTHER'S MAIDEN NAME First <i>Mary</i>	Middle <i>Katchska</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>YES</i>	16b. SOCIAL SECURITY NO. <i>WW# 1 335-10-3482A</i>	17 INFORMANT (WIFE 838-3536) <i>Mrs. Ruth H. LABRENZ</i>	18 ADDRESS <i>102 West Belcrest Road Bel Air, Maryland 21014</i>						
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b) and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac Decompenstation</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>4/24</i>									
(b) <i>arterio-sclerotic Cardiovascular Disease</i>									
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized Arteriosclerosis</i>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) <i>Pulmonary Emphysema</i>									
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING ETC) <i></i>	21f. LOCATION Street or R.F.D. No	City or Town	County	State				
22a. I certify that (I) (this hospital) attended the deceased from <i>1-23</i> , 19 <i>69</i> , to <i>1-24</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>1-24</i> 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Dante U. Monakil, M.D.</i>	22c. DEGREE <i>M.D.</i>	ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. DATE SIGNED <i>1/25/69</i>						
22d. PHYSICIAN'S NAME (Type) <i>DANTE U. MONAKIL, M.D.</i>	22e. ADDRESS <i>211 N. Union Ave. Havre de Grace, Md.</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Jan. 27, 1969</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Zion Meth. Ch. Cem.</i>	23d. LOCATION (City or Town) <i>BEL AIR, HARFORD CO., MARYLAND</i>	(County) <i></i>	(State) <i>21014</i>				
24. FUNERAL DIRECTOR <i>Joseph William Foster</i>	ADDRESS <i>W. Broadway &amp; Williams St. Bel Air, Maryland 21014</i>	25a. RECEIVED BY REGIST. <i>JAN 28 1969</i>	26a. REGISTERED BY <i></i>						
VR. A15 147 45M 1.69									



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1919

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it may be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)			First <i>Rosa Mae</i>	Middle <i>Lee</i>	Last <i>Lee</i>	2a. DATE OF DEATH Month <i>January</i>	Doy <i>14</i>	Year <i>1969</i>	2b. HOUR <i>6 AM</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>	5. DATE OF BIRTH <i>August 26, 1890</i>			6. AGE (In years last birthday) <i>78 yrs</i>		7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. COUNTY OF DEATH <i>Harford</i>					
10. CITY OR TOWN OF DEATH <i>Havre de Grace</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Mem Hosp</i>			12a. USUAL OCCUPATION (Kind of work done during most of work reg. life, even if retired) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Homemaker</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>Md</i>		13b. CITY OR TOWN <i>Harford</i>		13c. CITY OR TOWN <i>Bel Air</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>9 Dellam Prince</i>			
14. FATHER'S NAME First <i>Archer</i>		Middle <i>Lee</i>	Last <i>Coale</i>	15. MOTHER'S MAIDEN NAME First <i>Mary</i>			Middle <i>Alice</i>	Last <i>Jones</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOC SECURITY NO <i>215-01-3995 D</i>		17. INFORMANT (NAME 838-3758) <i>Mrs. Mary Ruth Gilbert</i>			18. ADDRESS <i>816 Rock Spring Avenue Bel Air, Maryland 21014</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30 min.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac Arrhythmia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Partial entestinal obstruction</i>											
19a. DATE OF OPERATION <i>NONE</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. A-TOPS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>JAN 9, 1969</i> , to <i>JAN 14, 1969</i> , that (I) (we) last saw the deceased alive on <i>JAN 14, 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Charles J. Foley Jr. M.D.</i>		ATTENDING DEGREE PHYS		<input checked="" type="checkbox"/> MED. DIRECTOR		<input type="checkbox"/> STAFF PHYS		22c. DATE SIGNED <i>JAN. 14, 1969</i>			
22a. PHYSICIAN'S NAME (Type) <i>CHARLES J. FOLEY JR. M.D.</i>		22e. ADDRESS <i>Havre de Grace, Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>JAN. 16, 1969</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Churchville Presbyterian Ch. Cem.</i>			23d. LOCATION (City or Town) <i>Churchville, Harford Co., Md.</i>		(County) <i>21028</i>		(State)
24. FUNERAL DIRECTOR <i>Joseph William Foster</i>		ADDRESS <i>W. Broadway &amp; Collins St. Bel Air, Maryland 21014</i>		25a. DATE <i>JAN 16 1969</i>			25b. PRACTICING LICENSE NUMBER <i>new garage</i>				



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

00925

00920

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <b>Nellie</b>	Middle <b>Kent</b>	Last <b>Lowe</b>	2a. DATE OF DEATH Month <b>JANUARY</b> Day <b>26</b> Year <b>1969</b>	2b. HOUR <b>A</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	S. DATE OF BIRTH <b>OCT. 19, 1905</b>	6. AGE (In years lost/birthday) <b>65</b> YRS.	F. UNDER MONTHS YEAR DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>TYLESVILLE, Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Hartford</b>		
10. CITY OR TOWN OF DEATH <b>Havre de Grace</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Hartford Mem Hosp.</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Perry Hall MANOR</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>Md</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>Fox Hill Ct.</b>		
4. FATHER'S NAME First <b>HARRY</b>	Middle <b>H. KENT</b>	14. MOTHER'S M AIDEN NAME First Middle <b>MARY M. RICHARDSON</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <b>No</b>	16b. SOCIAL SECURITY NO. <b>216-16-7224</b>	17. INFORMANT <b>B. Roy Lowe, PERRY HALL, Md.</b>	18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>?</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Unconsciousness, etiology</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Not determined</b> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>(Dr. Palmer was notified at 1 Am on 1/26/69).</b>					
19a. DATE OF OPERATION <b>1/26/69</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>None</b>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <b>None</b>	21b. TIME OF INJURY HOUR A.M. Month Day Year PM <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>None</b>			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <b>None</b>	21f. LOCATION Street or R.F.D. No <b>None</b>	City or Town <b>None</b>	County <b>None</b>	State <b>None</b>
22a. I certify that (I) (this hospital) attended the deceased from <b>1/26</b> , 19 <b>69</b> , to <b>1/26</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1/26</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Edward C. Loo, M.D.</b>	DEGREE <b>None</b>	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <b>1/26/69</b>
22d. PHYSICIAN'S NAME (Type) <b>Edward C. Loo, M.D.</b>	22e. ADDRESS <b>Havre de Grace, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>1-28-69</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>SLATE RIDGE</b>	23d. LOCATION (City or Town) <b>DELTA</b>	(County) <b>YORK</b>	(State) <b>Pa.</b>
24. FUNERAL DIRECTOR <b>JOHN H. HARKINS, DELTA, Pa.</b>	ADDRESS <b>None</b>	25a. REC'D BY REGISTRAR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. If Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												00921			
Items #13b,c,d,&e, Film GH09 2/4/CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or print)	First Mabel	Middle S.	Last Lynch	2d. DATE OF DEATH Month Day Year 26 69			2b. HOUR 45 PM								
3. SEX Female	4 RACE W			5 DATE OF BIRTH Aug. 25, 1888			6. AGE (In years last birthday) 80 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN					
7d. BIRTHPLACE (State or foreign country) Md	7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED WIDOWED			9. COUNTY OF DEATH Harford								
10. CITY OR TOWN OF DEATH Havre de Grace				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hartford Memorial				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md	13b. COUNTY Baltimore			13c. CITY OR TOWN Hartford			13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 38 E. Fair St., Abell West End Nursing Home					
14. FATHER'S NAME Robert	First	Middle	Last	15. MOTHER'S MAIDEN NAME Smith			16. ADDRESS Elizabeth McDowell								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	16b. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Harry F. Deherty, Wilmington, Del.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). (b) Caemalystinosis DUE TO, OR AS A CONSEQUENCE OF stating the underlying cause lost. (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2. 0-1 yr			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Acute Bronchitis pneumonia															
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No			City or Town			County State					
22a. I certify that (I) (this hospital) attended the deceased from 1-24, 1969, to 1-26, 1969, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED Jan 27, 1969			
22b. SIGNATURE Ernest W. Seiter	22d. PHYSICIAN'S NAME (Type) Ernest W. Seiter	22e. DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22f. ADDRESS RISWB Sun 140												
23a. BURIAL, CREMATION, BURIAL Cremation (Specify)	23b. DATE 1/28/69	23c. NAME OF CEMETERY OR CREMATORIUM Rose Bank Cemetery			23d. LOCATION (City or Town) Calvert, Md.			(County)			(State)				
24. FUNERAL DIRECTOR Ralph E. Hicks	ADDRESS Hicks Home for Funerals, Elkton, Md.			25a. REC'D BY REGISTRAR JAN 30 1969			25b. REGISTRAR'S SIGNATURE Ralph E. Hicks								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, sign page 1 and 2 director, page 3 should be detached for use as the burial transit permit. Then please remove the burial paper and file within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00922

1. DECEASED NAME (Type or print)	First <u>MARY</u>	Middle <u>CATHERINE</u>	Last <u>MALM</u>	2a. DATE OF DEATH Month <u>January</u>	Day <u>26</u>	Year <u>1969</u>	2b. HOUR IF UNDER 1 YEAR MONTHS <u>9</u>	IF UNDER 24 HRS DAYS HOURS MIN <u>A</u>		
3. SEX <u>Female</u>	4. RACE <u>White</u>	5. DATE OF BIRTH <u>11/29/1897</u>	6. AGE (In years lost birthday) <u>71</u>							
7a. BIRTHPLACE (State or foreign country) <u>Md</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <u>HARFORD</u>							
10. CITY OR TOWN OF DEATH <u>HAURE DE GRACE</u>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>HARFORD Memorial Hosp</u>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>SAME</u>							
3a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Md.</u>	13c. CITY OR TOWN <u>HARFORD</u>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <u>613 S. Washington</u>							
14. FATHER'S NAME <u>MARTIN</u>	First <u>7.</u>	Middle <u>ABBOTT</u>	Last <u>CATHERINE</u>	15. MOTHER'S MAIDEN NAME First <u>MC NULTY</u>	Middle <u></u>	Last <u></u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u>	16b. SOCIAL SECURITY NO. <u>Ma</u>	17. INFORMANT <u>MR. FRED SCHOPFER</u>	Address HARFORD DE GRACE, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410.0</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <u>Arteriosclerotic Cardiovascular</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Disease</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardiovascular</u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Small bowel fistula</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Intestinal obstruction</u>			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory (office building, etc.)		21f. LOCATION Street or R.F.D. No	City or Town		County	State		
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1</u> , 19 <u>69</u> , to <u>Jan 26</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Jan 26</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE <u>Charles J. Foley Jr. M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED				
22d. PHYSICIAN'S NAME, Type <u>CHARLES J. FOLEY JR. M.D.</u>		22e. ADDRESS <u>HAURE DE GRACE, Md.</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1/29/1969</u>		23c. NAME OF CEMETERY OR CREMATORIUM <u>MT. ERIN CEMETERY</u>		23d. LOCATION (City or Town) <u>HAURE DE GRACE HARFORD</u>			(County) <u>Md.</u>	(State)
24. FUNERAL DIRECTOR <u>Conroy &amp; Son Harde Grace, Md.</u>		ADDRESS		25a. REC'D. BY REGISTRAR DATE <u>JAN 31 1969</u>			25b. REGISTERED & SIGNATURE <u>Peter J. Foley</u>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

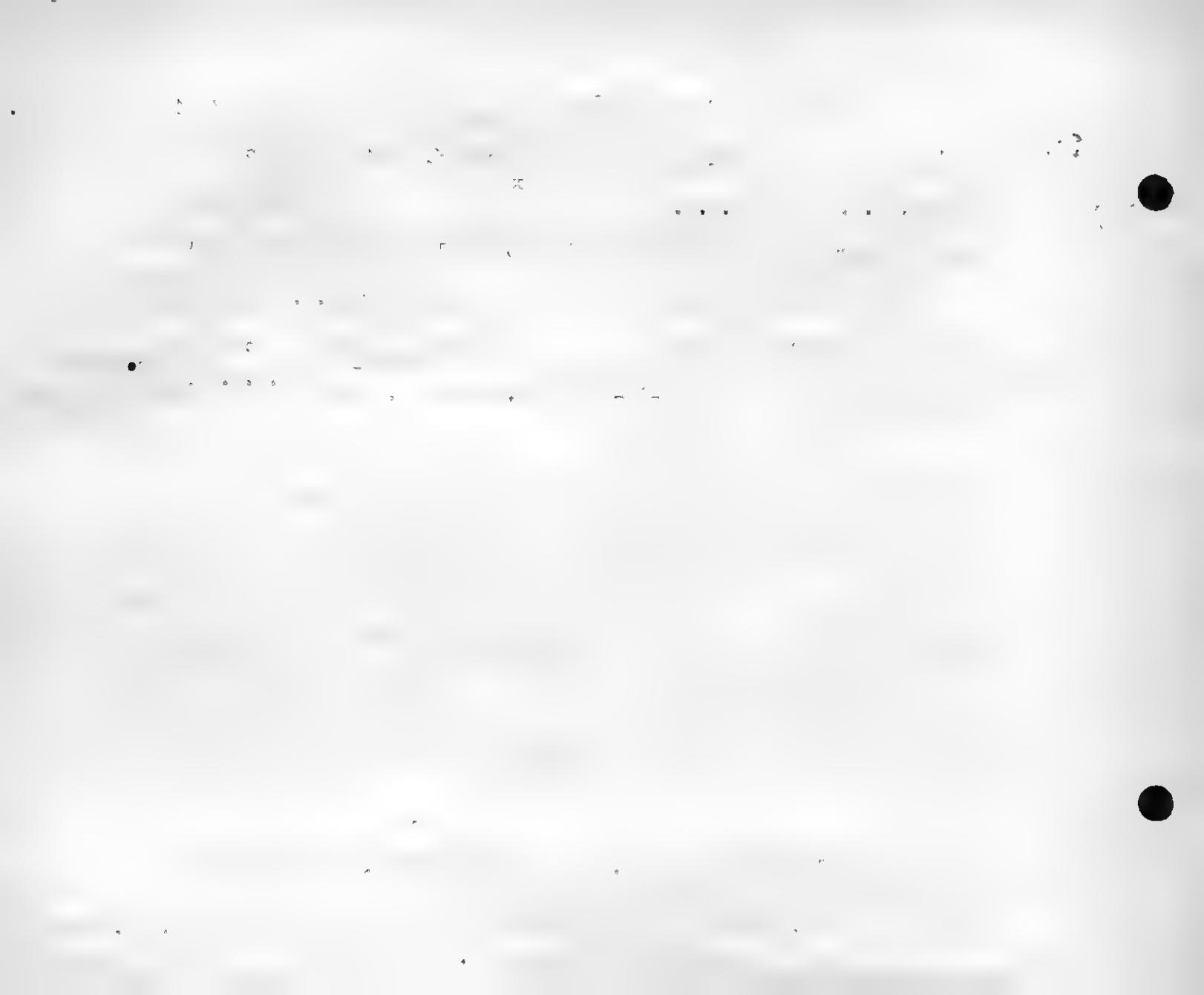
CERTIFICATE OF DEATH

00923

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print) <b>Rayvaughn Curtis Miller</b>				First	Middle	Last	2a DATE OF DEATH Month Day Year <b>January 25, 1969</b>	2b HOUR <b>5:50 PM</b>
3 SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>March 5, 1921</b>		6 AGE (In years last birthday) <b>47 yrs.</b>	IF UNDER 16 YEARS MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>
7a BIRTHPLACE (State or foreign country) <b>Ashe Co., N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Harford County,</b>		
10. CITY OR TOWN OF DEATH <b>Havre de Grace</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Harford Memorial Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most working life even if retired) <b>Service Station Attendant</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Petroleum</b>		
13a USUAL RESIDENCE (Where deceased admitted) STATE <b>Maryland</b>		13b COUNTY <b>Harford</b>		13c CITY OR TOWN <b>Bel Air</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER <b>R.F.D. #1, Box #90</b>	
14. FATHER'S NAME First <b>Sidney</b>		Middle <b>Abner</b>	Last <b>Miller</b>	15. MOTHER'S MAIDEN NAME First <b>Esther</b>		Ethel	Cockerham	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW#2</b>		17 INFORMANT (Wife) <b>838-9473</b>		Address <b>R.F.D. #1, Box #90</b>		
18. OTHER CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No.		City or Town	County	State
<b>22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</b>								
22b. SIGNATURE <b>Dudley Phillips</b>		DEGREE <b>M.D.</b>	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <b>1/27/69</b>		
22d. PHYSICIAN'S NAME (Type) <b>Dudley Phillips, M.D.</b>		22e. ADDRESS <b>Darlington, Maryland 21034</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Jan. 29, 1969</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Bel Air Memorial Gardens</b>		23d. LOCATION (City or Town) <b>Bel Air, Harf. Co., Md. 21014</b>		(County) (State)
24. FUNERAL DIRECTOR <b>Joseph William Foster</b>		ADDRESS <b>W. Broadway &amp; Williams St. Bel Air, Maryland 21014</b>		25a. REC'D BY REGISTRAR <b>JAN 29 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with your files. \$ may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00924

1 DECEASED-NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OR ESTI- MATED	Month	Day	Year	2b HOUR	
		<i>Norton Harold Newberry</i>			<input checked="" type="checkbox"/>	5	2	1969	M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 F UNDER 1 YEAR MONTHS DAYS HOURS MIN.	2c DATE PRONOUNCED DEAD Month	Year	19	2d HOUR		
M	W	5-19-09	59 YRS		Jan	1	69	4PM		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH					
Pa.		USA			Harford					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
<i>Abingdon</i>		<i>605 Long Bar Rd</i>			<i>Construction Inspector - US-Govt.</i>					
13a US/JAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b CITY OR TOWN			13d INSIDE CITY LIMITS?	13e. STREET AND NUMBER			Harbor	
Md		<i>Harford Abingdon</i>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<i>605 Long Bar Harbor Rd</i>				
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME	First	Middle	Last		
Scott		Winfield		Newberry	Jennie	--		May		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS				
no				187-03-6347	Norton Scott Newberry, 605 Long Bar Harbor Rd.	Abingdon, Md.				
18b CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		<i>Coronary Occlusion</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
{ 11C9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }		DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No.			City or Town	County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Gerald C. Palmer</i>		M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Bethel M. Palmer</i>			22b. DATE SIGNED <i>1-1-69</i>		
EXAMINER'S NAME (Type)		Gerald C. Palmer, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
23a BURIAL, CREMATION, REMOVAL. (Specify)		23b DATE	23c NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d LOCATION (City or Town) Aldino			(County)	(State)
Burial		Jan. 4/1969	Harford Memorial Gardens			Harford			Md.	
24 FUNERAL DIRECTOR		ADDRESS			25a REG'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE				
Howard K. McComas & Son, Abingdon, Md.					JAN 3 1969	<i>Charles Judge</i>				
VR A15ME (5) 10M REV 1/68										



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

66925

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, ~~in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with n/72 hours after death.~~

1. DECEASED NAME (Type or print)		First <i>Lomia</i>	Middle <i>Kansas</i>	Last <i>Frazier</i>	20. DATE OF DEATH Month <i>1</i>	Day <i>7</i>	Year <i>69</i>	2b. HOUR IF UNDER 1 YEAR MONTHS <i>5</i>	IF UNDER 24 HRS DAYS <i>5</i>	MIN <i>R</i>	
3. SEX <i>Female</i>	4. RACE <i>Wh.</i>	5. DATE OF BIRTH <i>15 Aug 1898</i>			6. AGE (In years last birthday) <i>70</i> YRS						
7a. BIRTHPLACE (State or foreign country) <i>Marion, Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH <i>Hartford</i>					
10. CITY OR TOWN OF DEATH <i>Havre de Grace</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hartford Memorial</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Rd 3 Box 258</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>Md</i>		13b. CITY OR TOWN <i>Hartford</i>		13c. INSIDE CITY & M.T.S. <input type="checkbox"/> YES <input type="checkbox"/> NO		13d. STREET AND NUMBER <i>Aberdeen</i>					
14. FATHER'S NAME First <i>John</i>		Middle <i>Wesley</i>	Last <i>Frazier</i>	15. MOTHER'S MAIDEN NAME First <i>Sally</i>		Middle <i>Ambern</i>	Last <i>Noxxobox</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO <i>None</i>		17. INFORMANT <i>John W. Norman R.D. #3 Box 176 Aberdeen, Md.</i>		Address <i>21001</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>CEREBRAL VASCULAR ACCIDENT</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4-6</i> DAYS DUE TO, OR AS A CONSEQUENCE OF (b) <i>ADVANCED ARTERIOSCLEROSIS</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>PNEUMONIA</i> YEARS.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>12-25-1968</i> to <i>1-7-1969</i> , that (I) (we) last saw the deceased alive on <i>12-25-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE <i>Santiago Leyte-Vidal</i>		22c. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <i>Santiago Leyte-Vidal, M.D.</i>		22e. ADDRESS <i>Aberdeen, Maryland</i>		22f. DATE SIGNED <i>1-8-69</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>10 Jan 69</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Bel Air Mem Gardens</i>			23d. LOCATION (City or Town) <i>Bel Air, Maryland 21014</i>		(County) <i>(State)</i>		
24. FUNERAL DIRECTOR <i>Kenneth B. Lugo</i>		ADDRESS <i>Tarring Funeral Home Aberdeen, Maryland 21001</i>		25a. REC'D BY REGISTRAR <i>JAN 13 1969</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



3  
1

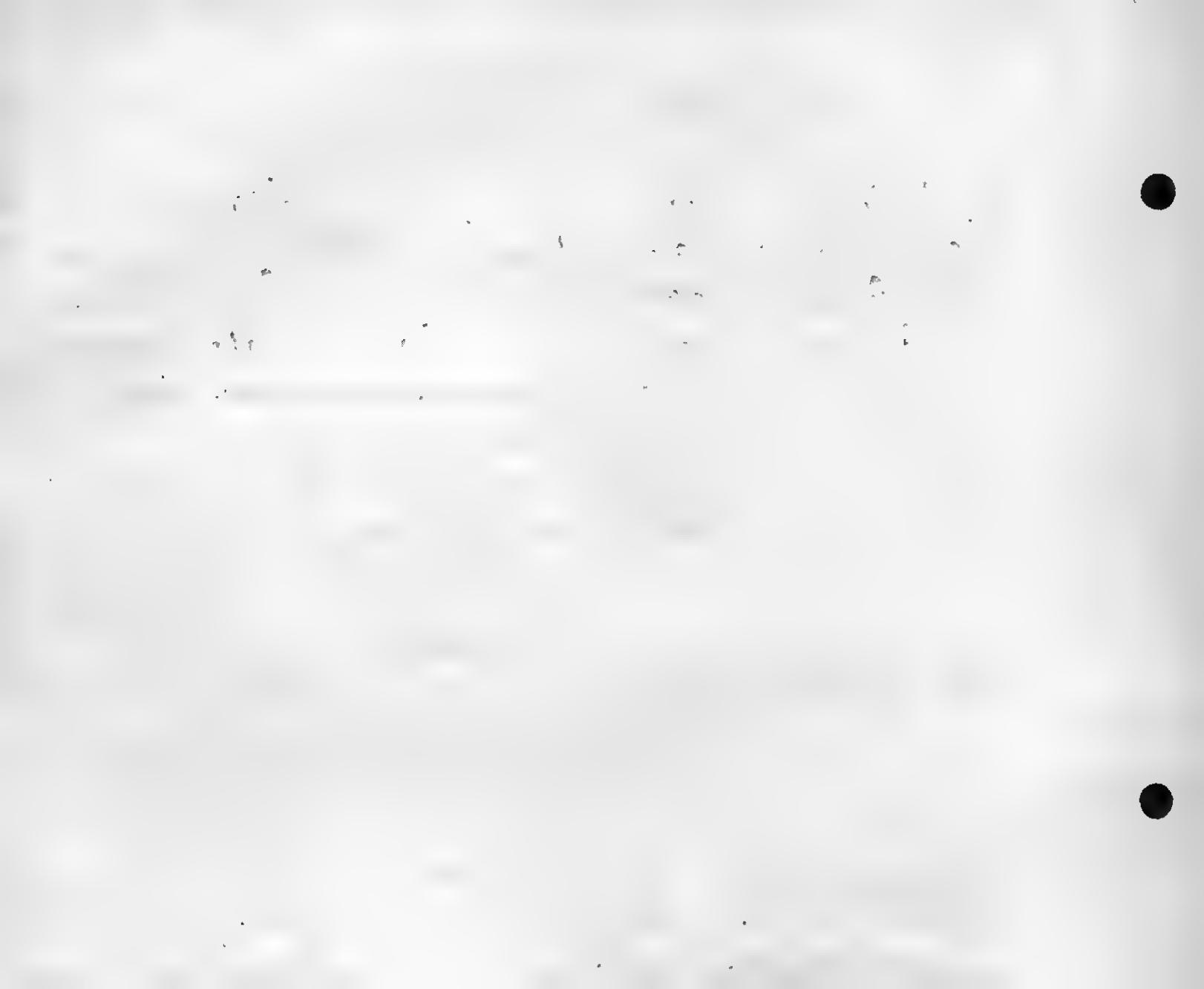
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First <b>Javnita</b>	Middle <b>Claris</b>	Last <b>PRITT</b>	2a. DATE OF DEATH 1. Month <b>13</b> Day <b>69</b> Year	2b. HOUR <b>7:25 AM</b>
3. SEX <b>f</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>April 20, 1927</b>		6. AGE (In years last birthday) <b>41</b> YRS
7a. BIRTHPLACE (State or foreign country) <b>W. Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED		9. COUNTY OF DEATH <b>Harcford</b>
10. CITY OR TOWN OF DEATH <b>Havre de Grace</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital g or street address) <b>Harcford Memorial</b>		12a. USUAL OCCUPATION (Kind of work done during most of work or life even if retired.) <b>Housekeeper</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>H</b>
13a. USUAL RESIDENCE (Where deceased lived, if institut admission) STATE <b>MD</b>		13b. COUNTY <b>Harcford Forest Hill</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <b>Casner Rd.</b>	
14. FATHER'S NAME First <b>Romey</b>		Middle <b>Winteris</b>	Last <b>Pritt</b>	15. MOTHER'S MARRIED NAME First <b>Susie</b>		Middle <b>Hinegarde</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO <b>227-34-9906</b>		17. INFORMANT <b>Donald R. Pritt, Bel Air, Maryland</b>		Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>180X</b>		DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chemiation, Dehydration</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>Colo-rectal - colo-cutaneous fistula</b>		DUE TO, OR AS A CONSEQUENCE OF (c) <b>Radiation trauma (La Canna?)</b>				<b>12/28/68</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b>Month</b> <b>Day</b> <b>Year</b> P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No		City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from <b>17 Dec</b> , 19 <b>68</b> , to <b>19 Jan</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>19 Jan</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>A.W. Grigoleit MD</b>		DEGREE <b>MD</b>	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <b>14 January 1969</b>
22d. PHYSICIAN'S NAME (Type) <b>A.W. GRIGOLEIT</b>		22e. ADDRESS <b>HARVE de GRACE, MD</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>16 Jan. 69</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Harford Memorial Gardens</b>		23d. LOCATION (City or Town) <b>Aberdeen, (Harford) Maryland</b>	(County) (State)
24. FUNERAL DIRECTOR Tarring Funeral Home, Aberdeen, Md. 21001		ADDRESS		25a. REC'D BY REGISTRAR <b>JAN 16 1969</b>	25b. REC'D STRA'S SIGNATURE <b>Charles J. Tarring</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

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20930

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**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First <i>Elizabeth Kate Quinn</i>	Middle	Last	2a. DATE OF DEATH Month <i>JAN</i>	Day <i>2</i>	Year <i>1969</i>	2b. HOUR <i>3:15 PM</i>
3 SEX <i>Female</i>	4 RACE <i>white</i>	S DATE OF BIRTH <i>8/3/1911</i>	6 AGE (in years lost birthday) <i>57 yrs</i>	IF UNDER 1 YEAR MONTHS <i>0</i>			
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	9. COUNTY OF DEATH <i>HARFORD</i>	IF UNDER 24 HRS DAYS <i>0</i>			
10. CITY OR TOWN OF DEATH <i>Havre de Grace</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Memorial Hosp</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USA/RESIDENCE (Where deceased resided, if institution, Reside before admission) STATE <i>MARYLAND</i>	13c. CITY OR TOWN <i>HARFORD</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>120 Weber St.</i>				
14. FATHER'S NAME First <i>Bellard</i>	Middle <i>Carter</i>	.0ST	15. MOTHER'S MAIDEN NAME First <i>Ethel Jennings</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>43-12-1200</i>	17. INFORMANT <i>Rosen Dugan</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days.</i>				
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Decompensation</i>		DUE TO, OR AS A CONSEQUENCE OF (b) <i>A.S. C.V.D.</i>				> 1 year	
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2/ OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <i>Post-influenza Pneumonitis</i> <i>② Bronchial asthma</i>							
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION <i>1/2/69</i>	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>None</i>	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour AM Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>None</i>					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No <i>None</i>	City or Town <i>Havre de Grace, Md.</i>				County <i>Harford Co.</i>
22a. I certify that (I) (this hospital) attended the deceased from <i>12/20/68</i> to <i>Jan. 2nd 1969</i> , that (I) (we) last saw the deceased alive on <i>Jan. 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <i>Edward C. Loo, M.D.</i>	22c. DEGREE <i>M.D.</i>	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <i>1/2/69</i>		
22d. PHYSICIAN'S NAME (Type) <i>Edward C. Loo, M.D.</i>	22e. ADDRESS <i>Havre de Grace, Md.</i>						
23a. BURIAL/CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>1/4/69</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Harford Mem Park Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Havre de Grace, Md.</i>				
24. FUNERAL DIRECTOR <i>Funerlco &amp; Son, Havre de Grace</i>	ADDRESS <i>111 Main Street, Havre de Grace, Md.</i>	25a. RECD BY REGISTRAR <i>Jan 6 1969</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

00932

10928

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from Pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Clarence W.	Middle Rake	Last	2a. DATE OF DEATH Month Jan	Day 20	Year 1969	2b. HOUR 5 P.M.
3. SEX m	4. RACE W			S. DATE OF BIRTH 14 July, 1896	6. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) W. Va.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED		9. COUNTY OF DEATH Harford				
10. CITY OR TOWN OF DEATH Haure de Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial		12a. LSJAL OCCUPATION (Kind of work done during most of working life, even if retired) Barber		12b. KIND OF BUSINESS OR INDUSTRY Barber Shop		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) Md	13b. COUNTY Harford	13c. CITY OR TOWN Harford		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 110 Beaver St.		
14. FATHER'S NAME Ralph M.		Middle Rake	Last (D)	15. MOTHER'S MAIDEN NAME Cappsie		Middle Balderson,	Last (D)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16b. SOCIAL SECURITY NO 232-28-4437		17. INFORMANT Jean Harbaugh, Aberdeen, Maryland		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost		Acute Myocardial infarction		DUE TO, OR AS A CONSEQUENCE OF Coronary thrombosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 5 days ?		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While Not while at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from Jan. 16th 1969 to Jan. 20 1969, that (I) (we) last saw the deceased alive on Jan. 20th 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Edward C. Loo, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 1/20/69				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Haure de Grace, Md.						
23a. BURIAL, CREMATION REMOVAL (Specify) Removal		23b. DATE 24 Jan. 69		23c. NAME OF CEMETERY OR CREMATORIUM Mt Olive Cemetery		23d. LOCAT ON (City or Town) Parkersburg, West Virginia		(County) (State)
24. FUNERAL DIRECTOR Tarring Funeral Home, Aberdeen, Md. 21001		ADDRESS		25a. RECD BY REGISTRAR JAN 23 1969		25b. REC'D BY SUPERVISOR jane jones		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00931 30929

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or by the hospital or attending physician, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First <b>Virginia</b>	Middle <b>Lenora</b>	Last <b>Renshaw</b>	2a. DATE OF DEATH Month <b>1</b>	Doy <b>7</b>	Year <b>69</b>	2b. HOUR <b>12:20PM</b>		
3 SEX <b>Female</b>	4 RACE <b>White Asian</b>	5 DATE OF BIRTH <b>5-24-90</b>		6 AGE (In years last b'day) <b>78</b>		IF UNDER 1 YEAR MONTHS <b>YRS.</b>		IF UNDER 24 HRS MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Harford</b>						
10 CITY OR TOWN OF DEATH <b>Havre de Grace</b>	11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>421 S. Union Avenue</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Harford</b>	13c. CITY OR TOWN <b>Abingdon</b>	13d. INSIDE CITY LIMITS? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>	13e. STREET AND NUMBER <b>806 Long Bar Harbor</b>						
14 FATHER'S NAME First <b>James</b>	Middle <b>Milheim</b>	Last <b></b>	15 MOTHER'S MAIDEN NAME First <b>Hulda</b>	Middle <b></b>	Last <b>Miller</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>	16b. SOCIA. SECURITY NO (If yes give war or dates of service) <b>179-20-5090</b>	17 INFORMANT <b>Brevin Nursing Home Record Card</b>		Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <b>PART I. DEATH WAS CAUSED BY</b> <b>IMMEDIATE CAUSE (a) 412 =</b> <i>Cardiac Decomposition and Pneumonia</i> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b),</b> <b>stating the underlying cause (c),</b> <i>Arterio Sclerotic Heart Disease</i> <b>DUE TO, OR AS A CONSEQUENCE OF</b> <b>(b) Arterio Sclerotic Heart Disease</b> <b>DUE TO, OR AS A CONSEQUENCE OF</b> <b>(c) Arterio Sclerosis</b>										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
<b>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory or office building, etc.)	21f. LOCATION Street or R.F.D. No	City or Town		County	State			
<b>22a. I certify that (I) (this hospital) attended the deceased from 8 - 30, 1968, to 1/7, 1969, that (I) (we) last saw the deceased alive on 1/6, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</b>										
22b. SIGNATURE <i>Dante U. Monakil, M.D.</i>		22c. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. DATE SIGNED <i>1/7/69</i>							
22d. PHYSICIAN'S NAME (Type) <b>Dante U. Monakil</b>		22e. ADDRESS <i>211 N. Union Ave. Havre de Gr., Md.</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Jan. 9, 1969</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Bel Air Memorial Gardens</b>		23d. LOCAT ON (City or Town) <b>Bel Air</b>		(County) <b>Harford</b>	(State) <b>Md.</b>		
24. FUNERAL DIRECTOR <b>Howard K. McComas &amp; Son, Abingdon, Md.</b>		25a. SEALED BY REGISTRAR DATE <b>JAN 9 1969</b>		25b. REGISTERED BY CLERK DATE <i>Howard K. McComas &amp; Son, Abingdon, Md.</i>						



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

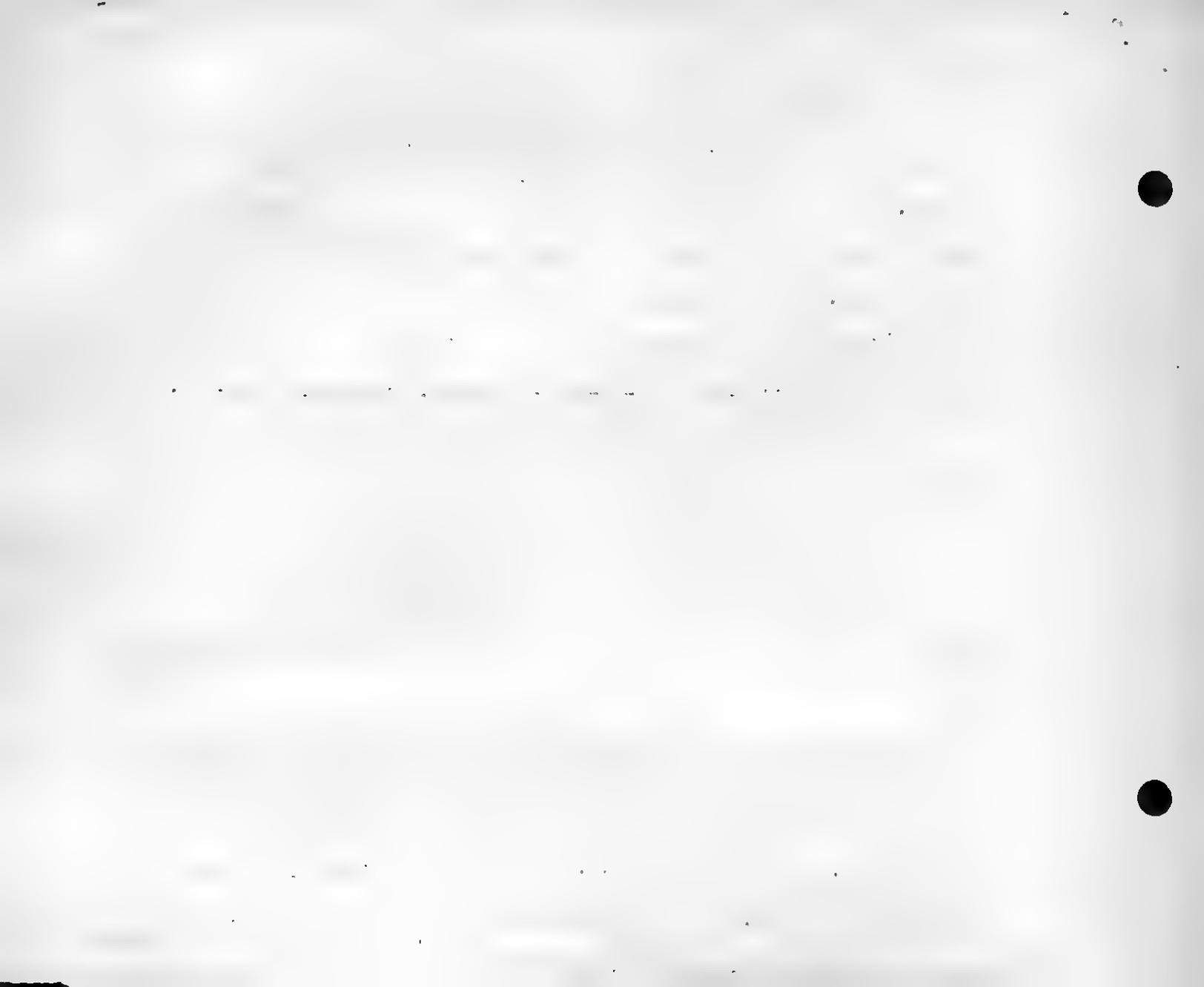
06930

06930

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR AM			
Benjamin			H	Sargable	1	14	69		6 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday) 79 yrs.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN			
male		white		05/07/89								
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford						
10. CITY OR TOWN OF DEATH Havre de Grace		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Citizens Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) carpenter			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Joppa		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1012 Pulaski Highway				
14. FATHER'S NAME Michael		First	Middle	Last	15. MOTHER'S MAIDEN NAME Sargable (D)		First	Middle	Last	Bechtold (D)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes		16b. SOCIAL SECURITY NO 1911-1912		17 INFORMANT Lula D. Sargable, Joppa, Md. 21085		Address			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4507 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b) Glaucoma and DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus								5 yr 10/12		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from 11/10, 1968, to 11/14, 1969, that (I) (we) lost saw the deceased alive on 11/13, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Dudley Phillips</i>		DEGREE ATTENDING PHYS		<input checked="" type="checkbox"/> MED DIRECTOR		<input type="checkbox"/> STAFF PHYS		22c. DATE SIGNED 1/15/69				
22d. PHYSICIAN'S NAME (Type) Dr. Dudley Phillips M.D.		22e. ADDRESS Darlington, Maryland										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 17 Jan. 69		23c. NAME OF CEMETERY OR CREMATORIAL Darlington Cemetery			23d. LOCATION (City or Town) Darlington, Maryland		(County) Maryland		(State)	
24. FUNERAL DIRECTOR Tarring Funeral Home, Aberdeen, Md. 21001		ADDRESS			25a. REC'D BY REGISTRAR DATE 20 1969			25b. REGISTRAR'S SIGNATURE <i>George</i>				



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

2093.

1931

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2. Please leave pages 1 and 2. Within 72 hours after death, this certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 6 months.

DECEASED NAME (Type or print)	First <i>Walter S.</i>	Middle <i>Scarf</i>	Last <i>Scarf</i>	2a. DATE OF DEATH Month Day Year <i>JAN 3 1969</i>	2b. MOHR <i>145 1/2 p.m.</i>
3. SEX <i>Male</i>	4. RACE <i>White</i>	S. DATE OF BIRTH <i>July 28, 1881</i>	6. AGE (In years last birthday) <i>87 yrs</i>	7. IF UNDER 1 YEAR MONTHS <i>0</i>	8. IF UNDER 24 HRS HOURS <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Harford</i>		
10. CITY OR TOWN OF DEATH <i>Havre de Grace</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address) <i>Harford Memorial Hosp</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Farmer</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Harford</i>	13c. CITY OR TOWN <i>Forest Hill</i>	13d. INSIDE CITY LIMIT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>Johnson Hill Road</i>	
14. FATHER'S NAME First <i>Israel Scarff</i>	Middle <i></i>	Last <i></i>	15. MOTHER'S MAIDEN NAME First Middle <i>Sara Elizabeth Windle</i>	Last <i></i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO <i>219-36-0685</i>	17. INFORMANT <i>Rosa H. Scarff</i>	Johnson Address <i>Hill Road</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinoma of the Rectum</i> 21050 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 mos.</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i></i>					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Fragile Pelvis - insuperable</i>					
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Carcinoma of the Body &amp; tail of the Pancreas</i> 3 mos.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)		
21d. INJURY OCCURRED While at work Not while at work		21e. PLACE OF INJURY (At Home, Farm, Street, Factory Office Building, Etc.) <i></i>	21f. LOCATION Street or R.F.D. No <i></i>	City or Town <i></i>	County <i></i>
22a. I certify that (I) (this hospital) attended the deceased from <i>1/27</i> , 19 <i>69</i> , to <i>3 Jan.</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>3 January</i> 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>W.H. Sadousky MD</i>		DEGREE <i>MD</i>	ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <i>3 Jan '69</i>	
22d. PHYSICIAN'S NAME (Type) <i>W.H. Sadousky MD</i>		22e. ADDRESS <i>504 Lems St., Havre de Grace, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>1/6/1969</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Bel Air Mem. Gardens</i>	23d. LOCATION (City or Town) <i>Bel Air, Harford, Md.</i>	(County) <i></i>	(State) <i></i>
24. FUNERAL DIRECTOR <i>Charles E. Kurtz Jarrettsville, Md.</i>	ADDRESS <i></i>	25a. REC'D. BY REGISTRAR DATE <i>JAN 7 1969</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Kurtz</i>		



FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First <i>William</i>	Middle <i>G.</i>	Last <i>Schaeffer</i>	2a DATE KNOWN OF ESTI- DEATH MATED	Month <i>JJ</i>	Day <i>1</i>	Year <i>69</i>	2b HOUR <i>M</i>				
3 SEX <i>M</i>	4 RACE <i>W</i>	5 DATE OF BIRTH <i>Feb. 22, 1917</i>		6 AGE (in years last birthday) <i>51</i> YRS	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS DAYS <i>0</i>	HOURS <i>0</i>	MIN. <i>0</i>	2c. DATE PRONOUNCHED DEAD Month <i>Jan</i>	Day <i>1</i>	Year <i>69</i>	2d HOUR <i>9A</i>	
7a BIRTHPLACE (State or foreign country) <i>Pa.</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Harford</i>								
10. CITY OR TOWN OF DEATH <i>Edgewood</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Cook</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Restaurant</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Edgewood</i>	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>2201 Pulaski Highway</i>							
4 FATHER'S NAME First <i>Samuel</i>		Middle <i>--</i>	Last <i>Schaeffer</i>	14 MOTHER'S MAIDEN NAME First <i>Gussie</i>		Middle <i>--</i>	Last <i>Bolton</i>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16b SOCIAL SECURITY NO (If yes give war or dates of service) <i>202-05-1306</i>		17 INFORMANT <i>Cyril Schaeffer, 436 Hess St., Schuylkill Haven, Pa.</i>		ADDRESS <i>Haven, Pa.</i>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Arteriosclerotic RV Disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
4123 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE OR CONDIT ON GIVEN IN PART I(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year HOUR A.M. P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Gerald C. Palmer</i>		EXAMINER'S NAME (Type) <i>Gerald C. Palmer, M.D.</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county) <i>Bell Air, Md.</i>		22b DATE SIGNED <i>1-1-69</i>						
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b DATE <i>Jan. 1, 1968</i>		23c NAME OF CEMETERY OR CREMATORIAL <i>Geschwindt Funeral Home</i>		23d LOCATION (City or Town) <i>Schuylkill Haven</i>		(County) <i>Pa.</i>		(State)			
24. FUNERAL DIRECTOR		ADDRESS <i>Howard K. McComas &amp; Son, Abingdon, Md. 21009</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE JAN 3 1969					



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

2093

20933

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 days after death.

1. DECEASED NAME (Type or print)		First <i>Sophia</i>	Middle <i>Hannah</i>	Last <i>Schneider</i>	20. DATE OF DEATH Month 1	Year 69	2b HOUR 9:30 P.M.
3. SEX <i>Female</i>	4 RACE <i>White</i>	5. DATE OF BIRTH 2-28-1906		6 AGE (In years last birthday) 62	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Md</i>	7b. CITIZEN OF WHAT COUNTRY? <i>A.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Harford.</i>			
10. CITY OR TOWN OF DEATH <i>Havre de Grace</i>		11. NAME OF HOSPITAL OR INST. LOCATED (If not in hospital give street address) <i>Hartford Memorial Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Reside before admission) STATE <i>Md</i>		13b. CITY OR TOWN <i>Harford Bel Air</i>	13c. CITY OR TOWN <i>Bel Air</i>	13d. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>18-5. Main St</i>		
14. FATHER'S NAME First <i>Joseph</i>		Middle <i>N.W.N. Baesop</i>	Last <i>Nettie</i>	15. MOTHER'S MAIDEN NAME First <i>Dawn</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO <i>NO</i>		17. INFORMANT <i>MR. REUBEN SCHNEIDER, 18 SOUTH MAIN ST.</i>	Address <i>BELAIR, MARYLAND</i>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Today</i>							
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Uremia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ca Right breast, metastatic</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Unknown</i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City of Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>12-30, 1968</i> , to <i>1-1-, 1969</i> , that (I) (we) last saw the deceased alive on <i>1-1- 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <i>A. W. Grigolet</i>		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <i>1/1/69</i>		
22d. PHYSICIAN'S NAME (Type) <i>A. W. Grigolet</i>		22e. ADDRESS <i>Havre de Grace</i>					
23a. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>1-5-1969</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>ANSHE EMUNAH ATZ CHAIM</i>		23d. LOCATION (City or Town) <i>Baltimore</i>	(County) <i>MARYLAND</i>	(State)
24. FUNERAL DIRECTOR <i>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</i>		ADDRESS <i>VR A15 45M</i>	25a. REC'D BY REGISTRAR <i>JAN 8 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Grigolet</i>		



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												66934
1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OR ESTI- MATED	Month	Day	Year	2b. HOUR		
<i>Sibbel Shepherd</i>						<input checked="" type="checkbox"/>	1-28	69	1969	M		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)	7. IF UNDER 1 YEAR MONTHS	8. IF UNDER 24 HRS DAYS	9. IF UNDER 24 HRS HOURS	10. IF UNDER 24 HRS MIN	2c. DATE PRONOUNCED DEAD Month	2d. HOUR		
F	W	MAY 21, 1891		70 yrs					JAN Day 28 Year 69	10A.M.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
N. Carolina		USA				Harford						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if not regular)			12b. KIND OF BUSINESS OR INDUSTRY			
Darlington			Patrick Rd.			Housewife			Own Home			
13a. U.S. RESIDENCE (Where deceased lived, if institution admission) STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER			
Maryland			Baltimore Ashland			YES <input type="checkbox"/> NO <input type="checkbox"/>			214 Ashland Rd.			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
Unknown					UNKNOWN	Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> or Unknown)			16b. SOCIAL SECURITY NO. (If yes, give date of birth and date of service)			17. INFORMANT			ADDRESS			
No			219-10-3454			Family Records						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Disease</i> +124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
									YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Gerald C. Palmer</i>			EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Baltimore, Md. 1-28-69			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Purifier</i>			23b. DATE 1/31/69			23c. NAME OF CEMETERY OR CREMATORIAL Poplar Grove Cem.			23d. LOCATION (City or Town) Pikesville Md. (County) (State)			
24. FUNERAL DIRECTOR <i>John Burns' Sons, Towson Md.</i>			ADDRESS			25a. REC'D BY REG STRAP FEB 3 1969			25b. REGISTRAR'S SIGNATURE <i>John Burns' Sons, Towson Md.</i>			
VR A15ME (5) 10M REV 1-68						DATE						



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in box 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for your files.

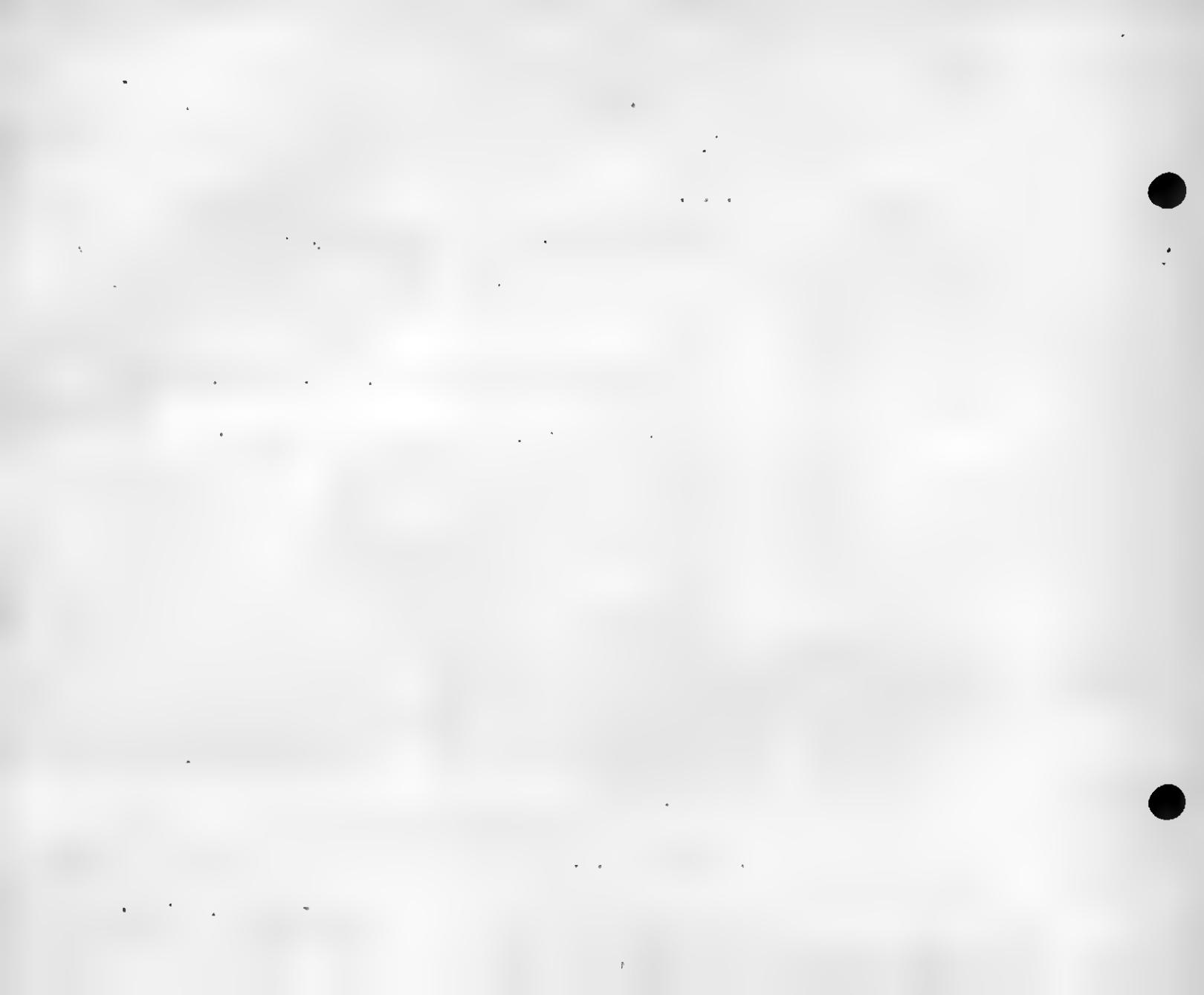
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0035

1. DECEASED NAME (Type or Print)			First <b>LILLIE</b>	Middle <b>Bell</b>	Last <b>SINGLETON</b>	2a. DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/>	Month <b>Jan</b>	Day <b>15</b>	Year <b>69</b>	2b. HOUR <b>8</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	S. DATE OF BIRTH <b>May 18, 1893</b>	6. AGE (in years last birthday) <b>75</b> YRS	7. IF UNDER 1 YEAR MONTHS <b>0</b>	8. IF UNDER 24 HRS DAYS <b>0</b>	9. IF UNDER 24 HRS HOURS <b>0</b>	10. IF UNDER 24 HRS MIN <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>Jan</b>	Day <b>15</b>	Year <b>69</b>	2d. HOUR <b>6</b>
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Harford</b>			
10. CITY OR TOWN OF DEATH <b>Havre de Grace</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Harford Memorial Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>			13b. CITY OR TOWN <b>Harford</b>			13c. CITY OR TOWN <b>Aberdeen</b>			13d. INSIDE CITY & MTS? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>	13e. STREET AND NUMBER <b>General Delivery</b>	
14. FATHER'S NAME First <b>John</b>			Middle <b>Elliott</b>	Last <b>(D)</b>	15. MOTHER'S MAIDEN NAME First <b>Mary</b>			Middle <b>Duff</b>	Last <b>(D)</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>220-14-7538</b>			17. INFORMANT <b>Mary Pinckney, Baltimore, Maryland</b>			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hemorrhage from varicose ulcer-right leg</b> DUE TO, OR AS A CONSEQUENCE OF <b>1540</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b) 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		
21f. LOCATION Street or R.F.D. No			City or Town			County			State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. (Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Gerald C Palmer</i>		EXAMINER'S NAME (Type) <b>Gerald C. Palmer, M.D.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>1-16-69</b>
EXAMINER'S NAME (Type)						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			ADDRESS (Street, city, town, or county) <b>Bel Air, Maryland</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>18 Jan. 69</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Baker Cemetery</b>			23d. LOCATION (City or Town) <b>Aberdeen, (Harford) Maryland</b>			(County) (State)	
24. FUNERAL DIRECTOR <i>Kenneth B Lange</i>		ADDRESS <b>Tarring Funeral Home, Aberdeen, Md. 21001</b>		25a. REGISTRY NUMBER <b>JAN 20 1968</b>			25b. REGISTRAR'S SIGNATURE <i>James L. Judge</i>			DATE	
VR A15ME IS, TOM REV 1/68											



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH	2b. HOUR		
		Hugh	E.	Smith Jr. 3rd.	JAN 11 1969	1815 M		
3. SEX		4. RACE		S. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 24 YEARS		
Male		Negro		JAN 11 - 1969	YRS MONTHS DAYS	MONTHS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH			
MD.		USA			HARFORD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Aberdeen Proving Ground		US Kirk Army Hospital		Infant		Infant		
13a. US/JAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
Md.		Harford		Aberdeen	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	2723 E 2nd Ave.		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First		
		Hugh	Elga	Smith, Jr.	Linda	Marie		
					Middle	Last		
					Blow			
16a. WAS DECEASED EVER IN US ARMED FORCES? Yes, no, or Unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No		N/A		Hugh E. Smith, Jr., 2723 E 2nd Ave., Md.		Aberdeen		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Primary Apnea DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). (b) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) Pneumonitis								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year PM 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>11 Jan 1969</u> to <u>14 Jan 1969</u> , that (I) (we) lost saw the deceased alive on <u>19</u> " <u>Jan 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		DEGREE	ATTENDING PHYS	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <u>11 Jan 69</u>		
22d. PHYSICIAN'S NAME (Type)		RICHARD H HELLER, CPT, MC						
23a. BURIAL, CREMAT. ON, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City or Town) Hampton,	(County) Virginia	(State)
Removal		14 Jan. 69		Hampton National Cemetery				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D. BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
		Tarring Funeral Home, Aberdeen, Md. 21001		JAN 16 1969				



## TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

3084~

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

00837

24 HOUR  
M

1. DECEASED NAME (Type or print)	First <i>Sadie</i>	Middle <i>Jane</i>	Last <i>Smith</i>	20. DATE OF DEATH Month Day Year January 24 1969	24. HOURS p	
3. SEX Female	4. RACE White	5. DATE OF BIRTH 4 May, 1886		6. AGE (In years last birthday) 82	7. IF UNDER 1 YEAR MONTHS YRS.	8. IF UNDER 24 HRS. DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>Va.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Hanford</i>	Md		
10. CITY OR TOWN OF DEATH <i>Hanape-de-Grace</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hanford Memorial Hospital</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE <i>Md</i>	13c. CITY OR TOWN <i>Hanford Magnolia</i>	13d. INSIDE CITY LIMIT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>Hanford Magnolia</i>			
14. FATHER'S NAME First <i>James</i>	Middle <i>Hayes</i>	15. MOTHER'S MAIDEN NAME First <i>Mary</i>	Middle <i>Berens</i>	Address <i>Frances Blevins, Magnolia, Maryland 21101</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown (If yes give war or dates of service) <i>No</i>	16b. SOCIAL SECURITY NO <i>215-54-2172</i>	17. INFORMANT <i>Frances Blevins</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Decompensation</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Arterio venous Fistula Cardiac -</i> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cular Disease</i>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Office Building, Etc.</i>	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>1-20</i> , 1969, to <i>1-24</i> , 1969, that (I) (we) last saw the deceased alive on <i>1-24</i> 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Daniel U. Moraki MD</i>		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <i>1/24/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>Daniel U. Moraki MD</i>		22e. ADDRESS <i>211 P. Union Ave. Hanford</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>25 Jan. 69</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Rosement Cemetery</i>	23d. LOCATION (City or Town) <i>Glade Springs, Virginia</i>	(County)	(State)
24. FUNERAL DIRECTOR Tarring Funeral Home, Aberdeen, Md. 21001		ADDRESS	25a. REC'D. BY REGISTRAR <i>JAN 28 1969</i>	25b. REGISTRAR'S SIGNATURE <i>Judge</i>		
VR A15 (4) 45M 1/69			DATE			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

20843 6938

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Lost	20. DATE OF DEATH Month	Day	Year	2b. HOUR
<i>Steele</i>		T.		<i>Snyder</i>	Jan.	12	69	7 P.M.
3. SEX	4. RACE	White		5. DATE OF BIRTH	6. AGE (In years last birthday)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
Female				01-23-95	73 yrs.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH				
<i>Md.</i>	<i>USA</i>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<i>Harcford</i>				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY			
<i>Houre de Grace,</i>	<i>Citizens Nursing Home</i>			<i>Street worker</i>	<i>U.S.A.</i>			
13a. USUAL RESIDENCE (Where deceased admitted) STATE	lived, if institution	Residence before	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER			
<i>Md.</i>	<i>Narfod</i>	<i>Houre de Grace</i>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<i>St Johns Towers Harford</i>			
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S Maiden Name	First	Middle	Last	
<i>OTIS</i>	<i>AMOS</i>	<i>TREADNAY</i>		<i>OLEITA VICTERIA</i>	<i>BRINEY</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO (If yes give war or dates of service)	17. INFORMANT	Address			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
<i>—</i>	<i>217-46-1793</i>	<i>Mrs. CLARK CONNELLEE</i>	<i>OAKINGTON, Md.</i>			<i>100-7</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i>								
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Seizure Cerebral</i>								
DUE TO, OR AS A CONSEQUENCE OF (c) <i>None</i>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING □ CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour AM Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>1/15</i> , 19 <i>68</i> , to <i>1/22</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>1/1</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		Dudley Phillips	DEGREE	ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			<i>DARLINGTON, Md. 21054</i>			<i>1/14/69</i>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION (City or Town)	(County)	(State)
<i>BURIAL</i>		<i>JAN. 15, 1969</i>	<i>WESLEYAN CHAPEL CEM.</i>			<i>HARFORD Co. Md.</i>		
24. FUNERAL DIRECTOR		ADDRESS			25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE		
<i>H. Madison Mitchell, Harford Co., Md.</i>					<i>JAN 16 1969</i>	<i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR of Month Days Hours Min
Homer Rouse Sprinkle					JANUARY 1 1969	2:55 P.M.
3 SEX Male		4 RACE White	5. DATE OF BIRTH Oct. 13, 1896		6 AGE (In years last birthday) 72 YRS	
7a. BIRTHPLACE (State or foreign country) VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DIVD <input checked="" type="checkbox"/> DIVDRCD		9. COUNTY OF DEATH Harford	
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital like street address) Harford Mem. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Hospital Attendant Retired		12b. KIND OF BUSINESS OR INDUSTRY P.T. INDUSTRIES, VA.
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md		13c. CITY OR TOWN Cecil		13d. INS'D CITY, M.I.P? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Box 68	
14. FATHER'S NAME LAFFAYETTE S.		Middle	Last	15. MOTHER'S MAIDEN NAME SPRINKLE SARAH		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES, WORLD WAR I		16b. SOCIAL SECURITY NO 199-07-7009		17. INFORMANT Harold L. Sprinkle		3515 LAURELWOOD DRIVE, NW HUNTSVILLE, ALA.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral anoxia</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last } (b) <i>Pulmonary edema</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASCVD</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 4 days Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE DEDUCTED ON GIVEN IN PART 1(a) <i>Hemorrhagic anemia due to pyloric channel ulcer -</i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from 12-24, 1968, to 1-1, 1969, that (I) (we) last saw the deceased alive on 1-1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>A.W. Grigoleit MD</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 1/1/69		
22d. PHYSICIAN'S NAME (Type) A.W. GRIGOLEIT		22e. ADDRESS HAURE de GRACE				
23a. BURIAL, CREMATION REMDVAL (Specify) CREMATION		23b. DATE JAN. 4, 1969	23c. NAME OF CEMETERY OR CREMATORIUM HARFORD MEMORIAL GARDENS		23d. LOCATION (City or Town) HARFORD, MD.	(County) (State)
24. FUNERAL DIRECTOR T. Macneill		ADDRESS Havre de Grace, MD.		25a. REC'D BY REGISTRAR DAN JAN 3	25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

00945

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First <i>Rufus</i>	Middle <i>G.</i>	Last <i>Thomas</i>	2a. DATE OF DEATH Month <i>JANUARY</i>	Day <i>11</i>	Year <i>1969</i>	2b. HOUR <i>6 A.M.</i>	
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>17 February 1937</i>	6. AGE (In years last birthday) <i>31</i>	7. IF UNDER MONTHS <i>YRS</i>	8. IF UNDER YEARS <i>0</i>	9. IF UNDER HOURS <i>0</i>	10. IF UNDER MIN <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>W. VA.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH <i>HARFORD</i>				
10. CITY OR TOWN OF DEATH <i>HARFORD GRACE</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>HARFORD Memorial Hospital</i>	12a. USUAL OCCUPATION (Kind of work done during most of adult life, even if retired) <i>Welder</i>				12b. KIND OF BUSINESS OR IND. STRY <i>Concrete Pipe</i>		
13a. USUAL RESIDENCE (Where deceased resided, if institution, Reside before adm ss an) STATE <i>Md</i>	13b. COUNTY <i>HARFORD</i>	13c. CITY OR TOWN <i>Aberdeen</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>643 Market St., 3822 N. HARFORD RD.</i>			
14. FATHER'S NAME First <i>Clarence</i>	Middle <i>Thomas</i>	Last <i>(D)</i>	15. MOTHER'S MAIDEN NAME First <i>Thelma</i>	Middle <i>Thomas</i>	Last <i>(D)</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>Yes</i>	16b. SOCIAL SECURITY NO. <i>Korean 232-56-8767</i>	17. INFORMANT <i>Eleanor M. Thomas, Aberdeen, Maryland</i>	Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Severe anemia &amp; metastasis</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to (immediate cause (a)), stating the underlying cause (b) <i>loss.</i>								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION <i>12-14-68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Distended Ostatomy</i>		20a. AUTOPSY? YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <small>If either, notify medical examiner</small>		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19 P.M.</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY RELATED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>12-4, 1968</i> , to <i>JAN. 11, 1969</i> , that (I) (we) last saw the deceased alive on <i>JAN. 11, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Wm. K. Brendle</i>		DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR	ATTENDING PHYS. <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>1-11-69</i>			
22d. PHYSICIAN'S NAME (Type) <i>William K. Brendle, M.D.</i>		22e. ADDRESS <i>HARFORD GRACE, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL, (Specify) <i>Burial</i>		23b. DATE <i>13 Jan. 1969</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Calvary Methodist Cemetery</i>	23d. LOCAT. ON (CITY OR TOWN) <i>Churchville, (Harford)</i>	(COUNTY) <i>Md.</i>	(STATE)		
24. FUNERAL DIRECTOR <i>Tarring Funeral Home, Aberdeen, Md. 21001</i>		ADDRESS	25a. REC'D BY REGISTRAR <i>JAN 14 1969</i>	25b. REGISTRAR'S SIGNATURE <i>Wm. K. Brendle, Judge</i>	DATE			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

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1. DECEASED NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month	Day	Year	2b. HOUR 10:45 PM
<b>JOHN WILLIAM TOMLIN</b>						<b>Jan</b>	<b>4</b>	<b>1969</b>	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday) YRS.		F UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
<b>MALE</b>		<b>CAN</b>		<b>9 JAN 1969</b>		<b>—</b>		<b>5 53</b>	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. COUNTY OF DEATH			
<b>MARYLAND</b>		<b>USA</b>		<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		<b>HARFORD</b>			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
<b>ABERDEEN</b>		<b>US KIRK ARMY HOSP</b>		<b>NO</b>		<b>Infant</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
<b>Maryland</b>		<b>Harford</b>		<b>A.P.G.</b>		<b>YES NO</b>		<b>2742 E. Augusta St.</b>	
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
<b>WILLIAM</b>		<b>T</b>	<b>Tomlin</b>		<b>DIANA</b>	<b>KAY</b>	<b>NICHOLS</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address
<b>No</b>			<b>None</b>			<b>William T. Tomlin, Aber Prov. Gd., Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Respiratory Distress</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 HRS</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>Aspiration</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					<b>YES NO</b>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <b>9 JAN 1969</b> , to <b>9 JAN 1969</b> , that (I) (we) last saw the deceased alive on <b>9 JAN 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <b>Samuel Kaye</b>		22c. DEGREE ATTENDING PHYS.		<input type="checkbox"/> MED. DIRECTOR		<input type="checkbox"/> STAFF PHYS.		22d. DATE SIGNED <b>9 JAN 69</b>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
<b>SAMUEL KAYE, CPT, MSC</b>		<b>US KIRK ARMY HOSP, A.P.G, MD</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>11 Jan. 1969</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Coleman Cemetery</b>		23d. LOCATION (City or Town) <b>Riverside</b>		(County) <b>Alabama</b>	(State)
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR <b>JAN 13 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			
Tanning Funeral Home, Aberdeen, Md. 21001									



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

00942

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove support papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>Jacob</i>	Middle <i>PHILLIP</i>	Last <i>WALTMAN</i>	2a. DATE OF DEATH Month <i>1</i>	Day <i>23</i>	Year <i>1969</i>	2b. HOUR <i>4:00PM</i>	
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>7-11-80</i>			6. AGE (in years last birthday) <i>88</i>	IF UNDER 1 YEAR MONTHS <i>YRS.</i>	IF UNDER 24 HRS. DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Harford</i>					
10. CITY OR TOWN OF DEATH <i>Havre de Grace</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Christen's Nursing Home</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Farmer</i>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Harford</i>	13c. CITY OR TOWN <i>Joppa</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>1700 Hanson Road</i>				
14. FATHER'S NAME First <i>John</i>	Middle <i>--</i>	Last <i>Waltman</i>	15. MOTHER'S MAIDEN NAME First <i>Annie</i>	Middle <i>--</i>	Last <i>Schillman</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>213-38-8484-A</i>		17. INFORMANT <i>Fenie Hein Waltman, 1700 Hanson Road, Joppa, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4:00</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Philip. et alia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause stating the underlying cause lost. (c) <i>arry. Serv. injuries.</i>								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY NOT OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> or work <input type="checkbox"/> Not at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug. 1, 1968</i> , to <i>Jan. 25, 1969</i> , that (I) (we) last saw the deceased alive on <i>Aug. 1, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>M. Mezei</i>		DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>Jan. 28, 1969</i>			
22d. PHYSICIAN'S NAME (Type) <i>Lajos Mezei</i>		22e. ADDRESS <i>Havre de Grace, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Jan. 28, 1969</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Trinity Lutheran Cemetery</i>			23d. LOCATION (City or Town) <i>Joppa</i>	(County) <i>Harford</i>	(State) <i>Md.</i>
24. FUNERAL DIRECTOR ADDRESS <i>Howard K. McComas &amp; Son, Abingdon, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 28 1969</i>			25b. REGISTRAR'S SIGNATURE <i>Charles George</i>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First <i>Mary</i>	Middle <i>C. Ward</i>	Last <i></i>	2d. DATE OF DEATH Month <i>1</i>	Day <i>15</i>	Year <i>79</i>	2b. HOUR <i>7:45 P.M.</i>
3 SEX <i>Female</i>	RACE <i>White</i>	S. DATE OF BIRTH <i>Nov. 11, 1882</i>	6. AGE (In years last birthday) <i>86 yrs</i>	IF UNDER 1 YEAR MONTHS <i></i>	IF UNDER 24 HRS DAYS <i></i>	HOURS <i></i>	MIN <i></i>
7a BIRTHPLACE (State or foreign country) <i>Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Harford</i>				
10. CITY OR TOWN OF DEATH <i>Havre-de-Grace</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hartford Memorial Hospital, Home-maker</i>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i></i>				12b. KIND OF BUSINESS OR INDUSTRY <i>Calvert Nursing Home</i>	
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>Md.</i>	13b. CITY OR TOWN <i>Cecil Rising Sun</i>	13c. CITY OR TOWN <i></i>	13d. INS'D CTY, J.M.T.S. <i>YES</i>	13e. STREET AND NUMBER <i></i>			
14. FATHER'S NAME First <i>Charles</i>	Middle <i></i>	Last <i>Ward</i>	15. MOTHER'S MAIDEN NAME First <i>J</i>	Middle <i>Alice</i>	Last <i>Fisher</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <i>Yes, no (or unknown)</i>	16b. SOCIAL SECURITY NO. <i>212-50-3221</i>	17. INFORMANT <i>Mrs Robert Kelley, Medway, Pa.</i>	Address <i></i>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Chronic Leucine</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>1980</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>1980</i>							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>20 days</i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION <i>Sept. 1, 1980</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>to the end</i>		20a. AUTOPSY? <i>YES</i> <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i></i>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>1-1-65</i> , 19 <i>65</i> , to <i>1-1-77</i> , 19 <i>77</i> , that (I) (we) last saw the deceased alive on <i>1-1-65</i> , 19 <i>65</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>John L. Patterson</i>		DEGREE <i></i>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>1-1-77</i>		
22d. PHYSICIAN'S NAME (Type) <i>John L. Patterson, M.D.</i>		22e. ADDRESS <i>118-1969 St. Mark's Cemetery, Purcellville, Cecil Md.</i>					
23a. BURIAL, CREMATION, REMOVALS (Specify) <i>Burial</i>		23b. DATE <i>1/18/1969</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Mark's Cemetery</i>	23d. LOCATION (City or Town) <i>Purcellville, Cecil Md.</i>	(County) <i>Cecil</i>	(State) <i>Md.</i>	
24. FUNERAL DIRECTOR <i>Lee G. Patterson, Sr., Purcellville, Md.</i>		ADDRESS <i></i>	25a. READ BY REG STRR <i></i>		25b. REGISTRAR'S SIGNATURE <i>John L. Patterson, Jr., Esq.</i>		
VR. A15 45M		DATE <i>JAN 28 1980</i>					



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

00944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) <b>Charles Leland Winn</b>			First Middle Last	20. DATE OF DEATH Month <b>January 29, 1969</b>	2b. TIME 10:30
3. SEX <b>Male</b>		4. RACE <b>White</b>	S. DATE OF BIRTH <b>Dec. 12, 1992</b>	6. AGE (In years last birthday) <b>78</b> YRS. IF UNDER 1 YEAR MONTHS    DAYS IF UNDER 24 HRS. HOURS    MIN	
7a. BIRTHPLACE (State or foreign country) <b>Donalds, South Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Harford County,</b>	
10. CITY OR TOWN OF DEATH <b>Bel Air</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>122 Stoneleigh Road</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Agent</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Harford</b>	13c. CITY OR TOWN <b>Bel Air</b>	13d. INSIDE CITY LIMITS? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>	13e. STREET AND NUMBER <b>122 Stoneleigh Road</b>
14. FATHER'S NAME First <b>Daniel</b> Middle <b>Henry</b> Last <b>Winn</b>		15. MOTHER'S MAIDEN NAME First <b>Frances</b> Middle <b>Elizabeth</b> Last <b>Seawright</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (or unknown) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>216-05-6006</b>	17. INFORMANT (Wife) <b>838-6892</b> Mrs. Mary Ruth Winn		Address <b>122 Stoneleigh Bel Air, Md. 21014</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive CV Disease</b> 4122 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from 1-1, 1965, to 1-29, 1969, that (I) (we) last saw the deceased alive on 5-1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Gerald C. Palmer MD</b>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <b>Jan. 30, 1969</b>
22d. PHYSICIAN'S NAME (Type) <b>Gerald C. Palmer, M.D.</b>		22e. ADDRESS <b>S. Main St., Bel Air, Md. 21014</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Feb. 1, 1969</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Bel Air Memorial Gardens</b>	23d. LOCATION (City or Town) <b>Bel Air, Harford Co., Md. 21014</b>	(County) (State)
24. FUNERAL DIRECTOR <b>John William Trotter</b>		25a. ADDRESS <b>W. Broadway &amp; Williams Bel Air, Maryland 21014</b>	25b. REC'D. BY REGISTRAR DATE <b>FEB 3 1969</b>	25b. REGISTRAR'S SIGNATURE <b>Judge</b>	
VR A15 30M REV. 168					

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00950

00945

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it may be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to carbon papers. Please send and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |  |  |   |  |  |
|---|--|--|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or print)   |  | First<br><b>RAY</b>  | Middle<br><b>ELMOR</b>   | Last<br><b>WOODS</b>  | 2a. DATE OF DEATH<br>Month<br><b>JAN</b>   | 2b. HOUR<br>Day<br>Year<br><b>22 1969 2 PM</b>             |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br><b>19 Feb 1911</b>                                   |   | 6. AGE (In years last birthday)<br><b>57</b>                                       |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>VIRGINIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>HARFORD</b>                       |
| 10. CITY OR TOWN OF DEATH<br><b>HARVE de GRACE</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>HARFORD MEMORIAL HOSPITAL</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Bookkeeper</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Farm Implement</b> |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>  |  | 13b. CITY OR TOWN<br><b>HARFORD</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 13e. STREET AND NUMBER<br><b>THOMAS RUN ROAD, RD 2</b>                             |  |
| 14. FATHER'S NAME First<br><b>Edward N. Woods</b>   |  | Middle   | Last   | 15. MOTHER'S MAIDEN NAME First<br><b>Edith Via</b>  |  | Middle   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown? <b>No</b>  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>M. J. Gaughn</b>  |  | Address<br><b>Route #1, Bel Air, Md. 21014</b>             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |  |  |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RENAL FAILURE &amp; OLIGURIA</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 DAYS</b>   |  |  |  |   |  |  |
| 5311<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>MASSIVE INTRAVASCULAR HEMOLYSIS</b> " "<br>(c) <b>ANTIBODY RECALL PHENOMENON TO A LOW FREQUENCY ANTIGEN</b> <b>VENCY</b>   |  |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>FAR ADVANCED CHRONIC - ACUTE PYELONEPHRITIS</b><br><b>MARGINAL GASTRIC ULCER &amp; PERFORATION</b>   |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At Home, Farm, Street, Factory, Office Building, Etc.)                                     |  | 21f. LOCATION Street or R.F.D. No.  | City or Town   | County   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/17, 1969</b> , to <b>1/22, 1969</b> , that (I) (we) last saw the deceased alive on <b>1/22, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Edward C. Loo MD</b>   |  |  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | DEGREE<br><b>MD</b>  | ATTENDING PHYS.<br><input checked="" type="checkbox"/>                   | MED. DIRECTOR<br><input type="checkbox"/>   | STAFF PHYS.<br><input type="checkbox"/>  | 22c. DATE SIGNED<br><b>1/22/69</b>                         |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal Burial</b>  |  | 23b. DATE<br><b>25 JAN 69</b>  | 23c. NAME OF CEMETERY OR CREMATORIUM<br><b>XXXXXX Evergreen Cemetery</b> |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Roanoke, Virginia</b>          |  |
| 24. FUNERAL DIRECTOR<br><b>Kenneth B. Gaughn</b>  |  | ADDRESS<br><b>Tarring Funeral Home Aberdeen, Maryland 21001</b>  | 25a. REGISTRAR BY REGISTRATION DATE<br><b>JAN 24 1969</b>                |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                 |  |

